Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Meeting of BNSSG CCG Governing Body

Date: Tuesday 1 September 2020
Time: 1.30pm
Location: The meeting will be accessible to members of the public. Please see our website for more details.

Agenda Number :	6.2
Title:	Recovery and Phase 3 Planning Summary
Purpose: For Information	
Key Points for Discussion: To brief Governing Body members on progress made on service recovery actions since the August update and to update on the national phase 3 planning guidance and to set out the approach BNSSG is taking to plan for the period August 2020 to end of March 2021.	
The following paper presents an update on service recovery actions since the update provided to Governing Body at its August meeting using the seven, first wave, goals as a structure to present key updates within. In addition an overview is provided of the approach BNSSG is taking to planning for Phase 3 in 2020/21 (the period August 2020 to March 2021 including: • A summary of the national Phase 3 planning guidance • The overview approach BNSSG is taking to conduct operational planning activities for Phase 3. • The key, national milestones around Phase 3 planning which need to be achieved.	
Recommendations:	The Governing Body is asked to note: • Updates relating to service recovery • The key requirements as set out within the 2020/21 phase 3 planning guidance • The approach the BNSSG system is taking to progress planning. • The milestones which need to be achieved.
Previously Considered By and feedback :	Recovery actions discussed at previous Governing Body meetings and as part of key system meetings including: • Healthier Together Executive Group • Silver Command • Capacity and Impact Cell

	Phase 3 planning guidance has informed discussions and work plans at the following recent meetings: • Healthier Together Executive Group • Finance and Analytics Cell • Capacity and Impact Cell • System Change Command Cell • BNSSG CCG Strategic Finance Committee
Management of Declared Interest:	None identified specifically related to this item.
Risk and Assurance:	Key risks: • **Timeliness.** As a result of the shortened phase 3 planning period there is a risk that, as a system, we will not be able to complete all planning activities in a timely fashion which may result in BNSSG missing nationally stated planning deadlines. To mitigate this the key deadlines have been shared widely and timelines developed that ensure all activities are completed on time. • **Affordability**. As a result of the lack of a national financial performance framework (unavailable at the time of writing) there is a risk that plans are not aligned and/or not affordable for the health system in the absence of clear allocations or funding streams for Phase 3. • **Future Covid-19 peaks** – scenario modelling is updated on a weekly basis however there are significant risks to the stability of the system if there are future peaks of Covid-19, particularly if this occurs in the winter months where pressures on the NHS are already expected.
Financial / Resource Implications:	As noted, at the time of writing allocations for the period September 2020 to March 2021 have not been issued therefore there remains significant uncertainty about the financial implications for the system.
Legal, Policy and Regulatory Requirements:	The CCG has a statutory duty to operate within its resource allocation each year and to meet regulatory requirements as described by NHSE/I.
How does this reduce Health Inequalities:	Covid-19 has particularly highlighted the need to focus on reducing health inequalities – particularly those inequalities that have arisen as a direct result of Covid-19. Phase 3 planning guidance has a key focus on the actions systems need to take to reduce inequalities. Existing recovery actions need to be impact assessed along with any changes proposed at part of Phase 3 planning.

How does this impact on Equality & diversity	There is significant diversity across our BNSSG population and any actions taken as part of phase 3 delivery need to be impact assessed – particularly when Covid-19 has been shown to have differential impacts on different populations groups.
Patient and Public Involvement:	Work to engage with and involve patients and public is undertaken within the projects and programmes of work which are outlined in this paper. Details of insight work which has been undertaken has been described in other papers for Governing Body in June and July, and in COVID-19 Recovery Planning reports to Governing Body, June 2020 and July 2020. The findings of these listening events are supporting the system's approach to phase 3 planning.
Communications and Engagement:	The insights team have been running listening events with the public over recent months and findings are supporting the system's approach to phase 3 planning.
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Agenda item: 6.2

Report title: Recovery and Phase 3 Planning

1. Background

The NHS has been operating its Covid response since March 2020 and the Governing Body have been receiving detailed updates on local service provision throughout the period. We have now moved into Phase 3 of the expected four-phase national NHS response. As a reminder the four phases can be summarised as follows:

Phase	Timeframe	Purpose
Phase 1 – Covid-19 level 4 incident Response	March 2020 – April 2020	• Enable NHS to deal with peak covid-19 demand
Phase 2 – Covid-19 level 4 incident response and critical services switch-on	May 2020 – July 2020	• Identify critical services risks and impacts during Covid-19 preparation and peak. • Start to restore safe service levels for critical services, lock in service innovation and signal re-start to some routine services. • Develop monitoring tools to measure and reassure.
Phase 3 – Ongoing covid-19 management and NHS open for business	August 2020 – March 2021	• Ensure capacity in place for ongoing covid-19 activity • Return critical services to agreed standards • Address backlog of services • Retain changes from pandemic we wish to keep
Expected Phase 4 – New NHS	April 2021 onwards	• BAU covid-19 service in place including sufficient critical care headroom • NHS priorities established

The purpose of this paper is to provide an update on service recovery in BNSSG and then describe in more detail the BNSSG approach to planning for Phase 3 following national guidance issued at the end of July 2020.

2. PART 1: Recovery Progress and Seven, First Wave Goals

Governing Body has received updates across a broad range of programme areas in recent months describing the actions that are being taken to restore services and ensure the needs of our population are best served. For this month's report the sections are provided under the banners of the system's seven, first wave goals to support recovery. As a system we have developed these goals to ensure cohesive action across BNSSG that will reshape the health and care system to deliver integrated, person-centred care. Our Phase 3 planning process, as described later in this paper, is using these goals as a guide to identify the key service development priorities that will best support achievement of the goals and support system delivery for the rest of this financial year and beyond.

Goal 1a – Urgent and Emergency Care

Community urgent care services will be supported by secondary care to resolve people's care needs at the time of presentation and without onward referral, except where clinically indicated. An integrated approach will be taken to ensure that people are influenced and directed to the right treatment option first time. This will ensure that Emergency Departments are not crowded and that

people use same-day primary care and community options for treatment ahead of seeking specialist emergency support.

Governing Body received a comprehensive update last month on the outputs following the system's Urgent and Emergency Care Workshop in July. The key programme areas being progressed include developing the 111 First service, creating an alternative to ED for emergency mental health presentations and developing unified teams between primary, community and secondary care. It is essential that these and other actions are put in place given the expected levels of demand as we enter another winter period, alongside the need to operate our EDs and urgent care service whilst adhering to IPC guidelines.

Goal 1b – Planned Care

The starting point for care provision will be what the person is aiming to achieve, recognising the increased risks to a person associated with Covid-19. (a) Telephone and digital consultation will be the default for all clinical communication, including between clinicians. (b) Clinical professionals will be able to access advice and guidance for all specialities (c). Triage of further care needs will happen once and be done well - the referral support service will be mandatory for all practices. (d) Face to face contacts will be organised to resolve all identified needs in a single visit; remote monitoring and other innovations will be drawn on to support information gathering about a person's clinical condition ahead of scheduled appointments

Hospital providers continue to work with specialty teams, wards, clinics and operating theatres to model likely capacity for routine and urgent procedures. Although capacity and demand models are still in development as part of Phase 3 planning, initial analysis suggests that capacity for routine elective inpatient and daycase surgery could be below 70% of pre-COVID-19 levels. Demand and Capacity modelling is also anticipating additional demand due to the backlog of treatments required for patients who are on waiting lists for routine procedures which have been on hold since March 2020, and a possible backlog of patients who have not presented to Primary Care during lock-down.

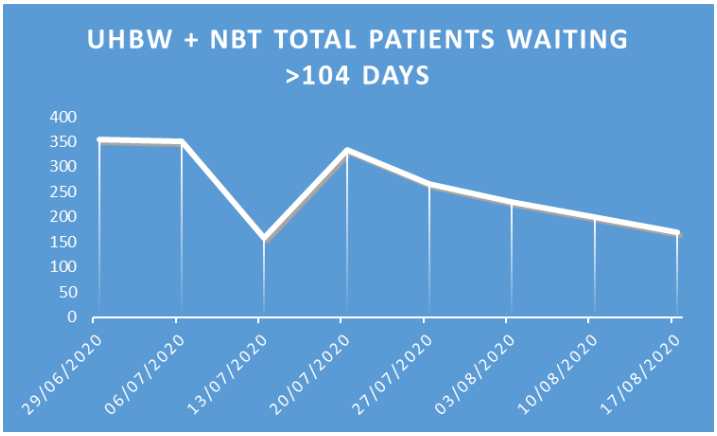
Note on Long Cancer Waiters >104 days

As requested at Governing Body last month the following information is provided on cancer long waiters in BNSSG and the reasons for the waits in excess of 104 days – with a particular question raised about patient choice. As noted in the table below 79 (58+21) out of 199 patients have patient choice recorded as the reason – this is taken from the weekly sit rep 10 August 2020.

Data from 10 August 2020 Trust Sit Rep reports - >104 day waits.

Delay Reason	Number of Patients		
	NBT	UHBW	Total across 2 trusts
Clinical Decision safer to delay due to COVID	40	7	47
Clinically complex pathway	6	10	16
Endoscopy service Suspension	34	5	39
Insufficient capacity	1	2	3
Late referral received from external Trust	4	1	5
Medical deferral unrelated to COVID	5	2	7
Patient choice related to COVID	24	34	58
Patient choice unrelated to COVID	3	18	21
Transferred to different treating Trust	2	0	2
Unknown - Escalated	1	0	1
Total	**120**	**79**	**199**

Based on the weekly data returns Governing Body will note an emerging downward trend from a level of 355 at the end of June to the current position of 170 for the most recent week ending 17 August 2020.



Adapt and Adopt

A key development to support recovery of planned care services is the national Adopt and Adapt programme. As the response to the Coronavirus pandemic continues, the NHS faces a significant challenge to recover planned care services, respond to new demand and address the backlog of patients waiting longer as a result of responding to the incident.

There are a number of challenges in recovering activity related to long term pressures and new constraints associated with the response to the pandemic, including:

- delivering activity with revised **Infection Prevention Control** measures to protect public, patients and staff impacting on relative risk and operational productivity.

- a **backlog of demand** from the pause of routine work in Phase 1, resulting from changes in public health-seeking behaviours, access to primary care for diagnosis & referral, & access to secondary care.
- **workforce capacity to continue to respond to the pandemic**, increase planned activity and take sufficient rest and recovery time in order to effectively sustain a response.
- **physical space and infrastructure** to adequately define Covid-minimal pathways for more efficient lists.
- progress with **testing and isolation** regimes for staff and patients to secure Covid-minimal pathways and manage risk.

In responding to the challenge, the Adopt & Adapt: Accelerating Planned Care Recovery Programme is one of a number of initiatives established to increase the pace at which the NHS recovers. A suite of high value interventions are being developed as part of this approach and BNSSG is participating in regional workshops to understand the opportunities and consider how the recommendations can most effectively be implemented locally.

High Impact Interventions that are currently being considered by the system include:

Adapt and Adopt Programme	Interventions
Diagnostics – CT/MRI	Reducing DNAs Optimising productivity and clinical time Using Nightingale Bristol as a diagnostics hub Maximising use of independent sector capacity Extending opening hours of existing scanners Reviewing pathways to reduce demand
Endoscopy	Optimising FIT and faecal calprotectin pathways Increasing use of CT colonography Extending hours of service operation Providing additional capacity via modular endoscopy units Maximizing use of the independent sector
Theatres	Case reviewing waiting lists Maximising staff through top of license working Use of independent sector Establish specialty partnerships between hospitals Weekend working Creating additional theatre space
Outpatients	Clinical validation of existing referrals and follow ups Advice and guidance and referral support Patient initiated follow ups Rolling out the first contact practitioner physio model.

Goal 2 – Care Providers

Care providers are an equal partner in the health and care system. Community and primary care will take an asset based approach, proactively and consistently responding to the needs of those providing care, ensuring that residents health requirements are addressed and care staff are well

supported. The system will actively work with the care providers to shape the market across the BNSSG footprint and support those providing care to meet the changing care needs of the population. Partners will work together to restore the public's confidence in care provision.

Summary of the key challenges:

- to support care homes in the BNSSG CCG footprint with a rapid return to business as usual
- to support care homes in response to C-19
- to support care homes with a reinforced return to market conditions
- to better understand care homes needs and improve public / resident trust in the care homes market and care providers' provision.

This will be done by:

- Wraparound support for care homes and other provision, led by Sirona, providing practical support and advice
- Infection prevention and control support to care homes, including training, advice, information and guidance
- Outbreak control management in partnership between PHE, LA Public Health, IPC Cell and Sirona Wraparound Support
- Enhanced primary care support to care homes (including named clinical leads)
- Access to weekly bulletins and online information, supported by a clinical reference group
- Scoping of further opportunities to make use of interim flats in extra care housing provision to support discharge following a pilot
- Development of the integrated D2A model by the Out of Hospital Delivery Group
- Work on a shared database and RAG rating approach to care homes across the system

The care provider cell has also been considering the issues arising from swabbing asymptomatic people in the community who need an urgent admission directly into a care home and for care providers who are unable to take swabs themselves. Discussions have taken place with the local authorities, community health provider and the CCG and a pilot scheme will commence shortly in which we will establish the demand for a community swabbing service.

Goal 3 – Vulnerable and Shielded People

Vulnerable and shielded people, those with learning disabilities and those with long-term conditions, will be proactively supported to self-care and stay independent. They will be offered access to the services they need in new and innovative ways (such as remote monitoring solutions and apps) that avoid multiple healthcare contacts. Principles will be developed to support a consistent approach across BNSSG and the voluntary sector will remain central to supporting people in their communities

The VCSE Cell has been supporting the delivery of care to our vulnerable and shielded population through COVID, with collaboration between the CCG, Social Care Providers, LAs, local voluntary organisations and community groups.

Area	Actions
1.1: **Coordination by LAs** (via helplines, community hubs, food banks and distribution)	From April 2020 to July, the VCSE has coordinated and delivered support within communities through its membership - resources are required for continuation
1.2: The Cell has worked with 27 different **community-led groups** and coordinated response and support through weekly meetings (>7,800 vulnerable and shielded people)	The Cell to continue supporting local groups and retain contact.
1.3: Linked to support in communities via **voluntary agencies** (Uncounted community mutual aid / good neighbours)	Improvements required to safeguarding: 'volunteer passports', to enable volunteers to provide support where required, with 'rolling DBS checks (Advanced Volunteering) - funding is required
1.4: **Specialist support to vulnerable** (e.g. Age UK). Support from NHS Responders	Need to review Vulnerable Lists to recognise those that are shielding through self-isolation (Track & Trace), not just those who are on GP vulnerable lists
1.5: For those **vulnerable and shielded discharged from hospital**: pilot involving VCSE is still underway and now looking at this role in admission avoidance (i.e. engagement with British Red Cross, identification of vulnerable and shielded within the community)	The Cell has been engaged with the Discharge Plan (D2A with new model of care for discharge using the CICB) to support those leaving hospital - VCSE Cell in full support of the new Model of Care (in place during C-19) and is aligned to continue support once the D2A process is signed off and agreed at Executive level, with funding in place for continuation

Goal 4 – Discharge/Out of Hospital

The community health and care system will continue to "pull" people out of hospital within 24 hours of being medically fit for discharge and assessed for ongoing care outside of the hospital environment. Adequate capacity in the localities will be available to make this possible.

The new community services provider for BNSSG, Sirona has been given the responsibility to facilitate all hospital discharges from hospital beds throughout BNSSG in line with the NHSE Hospital Discharge Guidance published on 19th March. This requirement has also necessitated a review of all existing hospital discharge pathways to streamline processes and ensure the system can meet the needs of a new cohort of individuals with post-Acute Respiratory Distress syndrome as well as the forecasted total level of demand for discharges from all hospitals

In developing the required demand and capacity tool for community services it has been important to consider the changing case mix that community services will be required to support as individuals are discharged from hospital as well as the need to meet the changing needs of individuals who will not be hospitalised and will receive their care including End of life care in community settings.

The work to develop the new approach to hospital discharge and admission avoidance care has been developed with all 3 Local Authorities in BNSSG as well as the voluntary sector cell established by the CCG to ensure that integrated models were designed that could be resourced in time for the projected peak of the outbreak. In particular it rapidly became evident that the

existing discharge pathways would not be able to resource the required level of support due to the number of individuals that would need care and would require health and social care and voluntary sector partners to devise new shared care pathways.

Pre-Covid features of the BNSSG system:

- Integrated Care Bureau (ICB) was managed within the acute trusts
- All assessment processes were continuing to be managed in an acute hospital bed base i.e. Social Work (SW) assessments and Continuing Health Care (CHC).
- The number of Medically Fit For Discharge (MFFD) and patients over 21 days was above target in all three acute trusts.
- Sirona had been appointed as the new Community Provider but we still has three Community Interest Company's (CIC) in March with different ways of working.
- The Discharge to Assess (D2A) capacity was very different across Bristol North Somerset South Gloucestershire (BNSSG).
- Flow within D2A was slow with high Delayed Transfers of Care (DTOCs) within community services.

Phase 1 and 2 changes made from April 2020 onwards:

Hospital Discharge Guidance published by HM Government and NHS 19 March 2019 supported that we should

- *Fully implement Discharge to Assess pathways led by Capacity & Impact Cell*
- *Suspend Care Act Assessments and CHC Assessments*
- *£1.3bn new national NHS fund created*

Therefore the following changes were made:

- ICB moved into the community in each locality 8/04/2020
- SW and CHC teams moved out to community to support CICB.
- Joint LA demand and capacity tool developed to support a full D2A model
- Additional P3 bed capacity for complex assessment were commissioned in each locality now managed as part of CICB process
- Joint BNSSG specification for complex beds developed across BNSSG
- MDT process developed in all acute providers including AWPT to support the very complex discharges that can't go out on standard pathways
- Sharing of capacity right across BNSSG
- Radical reduction in MFFD and stranded both within acute and community services

Phase 3

The Phase 3 planning letter has confirmed that funding for the hospital discharge scheme will continue to end of March, but will be limited to c6 weeks of intermediate care, and that CHC assessments must be reinstated. The Out of Hospital cell has therefore remodelled the capacity

and demand to work towards a trajectory from October 2020 to March 31st that now includes the expectation of LAs to pick up Social care assessments and for the CCG to manage ongoing CHC assessments within the community from September.
This has shown an impact of the expected LOS within the model, which we are currently working through.

Core Deliverables:
The new demand and capacity tool utilised devised 6 main pathways that were used to support the discharge of individuals from all hospital beds throughout BNSSG these are:

1. **Home First DTA Pathway 1.** Short-term rehabilitation for Sirona services for up to 10 days - this has used existing P1 staff but now an expectation for step down which is why Extra Care Housing (ECH) model included to support P1+.
2. **Community Bed Pathways 2 and 3.** Discharge to a community bed for short term rehabilitation (Pathway 2 bed for up to 21 days) or slower stream rehabilitation and assessment in a community bed for up to 28 days
3. **MDT complex cases.** Co-ordinated by the acute for the most complex patients that do not fit any of our standardised pathways and require a multiagency support plan to exit hospital'
4. **End of Life care pathway**
5. **Community nursing "lite" model**
6. **Voluntary Care Support (VCS) Pathway 0** including advice, signposting or mutual aid support including shopping, pharmacy support etc.

As well as reviewing the implications of phase 3 we are aware that all partners are keen for the model to continue as an integrated D2A model and therefore noting that this funding does not continue from April 2020 we are undertaking review of the following to sustain the model going forward,

Actions Required: areas that now urgently require further development and opportunities:

Area	Actions
Resource	• Confirming ongoing funding / resources to deliver the new agreed BAU capacity we now need in light of reduction in acute bed base. • Increase Therapy capacity to manage D2A model (home and bedded) and to get as many people back into their own home as possible • Continue to support care provision within intermediate care and out into long term care (i.e. manage fragile market)
Admission avoidance	• Further development and understanding the options for Admission avoidance. • Work alongside the voluntary sector to support pathway
Out of Hospital Home Bedded Capacity	• Utilisation of P1 including assistive technology • Utilisation of P1 + can be done with the extra care offer around night services and Extra Care Housing • BNSSG review of Rehab/Reablement interface
Performance monitoring	• Development of current data sets to monitor super cell across Health and Social Care and long term outcomes • Review of ICB digitalisation

Goal 5 – Mental Health

We will take a whole system approach to meeting people's mental health needs across BNSSG. Partners from across our communities, public health, primary care, secondary care, our voluntary sector and those with lived experience of mental illness, as well as partners such as the police and businesses - will plan together to effectively utilise all available resources, including the mental health investment standard, to meet the anticipated increase in mental health needs. People will have timely access to the right support, and we will focus on tackling health inequalities that COVID-19 has exacerbated. We will work to integrate people's mental and physical health needs to ensure they are well met and everybody is supported to thrive.

The system has supported the Business Case developed by the Mental Health and Wellbeing Cell. The priority is to build upon this whole-system approach to deliver new, targeted interventions, alongside existing provision, to mitigate the impact of increased mental ill health resulting from COVID-19.

The Mental Health and Wellbeing system will direct and oversee BNSSG's implementation of the Mental Health Strategy, Long Term Plan and Prevention Concordat, leading to significant service transformation (including delivery of the Community Mental Health Framework).

The deliverables listed below are some key changes coming during 20/21 (of 30 in total). However significant other developments are not captured here (including those focused on addressing key health inequalities), but are noted in the business case and implementation plans. These deliverables form a part of the delivery programme for BNSSG's Mental Health Strategy and direct ongoing system transformation.

The Mental Health and Wellbeing system will embed whole system metrics to understand changes in mental health need in real-time to enable a targeted and effective response. Specific deliverables will have their own KPIs developed to measure success

Area	Actions
Prevention: - We will deliver large scale mental health prevention support (within 'Thrive West') including the roll out of mental health training and trauma-informed support, focusing on communities disproportionately impacted by COVID-19	We aim to upskill community volunteers / organisations and faith leaders to enable them to: - Offer timely and effective support and interventions. This may include training in mental health awareness; suicide prevention; trauma and bereavement; listening skills and safety planning (using evidence-based training). - Help people to quickly access support in the right place at the right time (preventing further deterioration) – ensuring our volunteers and community organisations have clear and up-to-date information on local provision. - Share public mental health information and support on how people can manage their mental health; tailoring this to the communities they serve. This will include work to tackle stigma, especially in communities and settings where this is high and prevents people seeking support, and involve work undertaken in community languages. - If funding allows, we would increase support to include drug and alcohol support.

	150 evidence-based mental health courses will be run over 12 months. This has a reach of around 3,000 people across BNSSG receiving evidence-based mental health training. As we will be focusing upon those who are volunteers / faith and community leaders then its reach will be significantly higher.
Children and Young People: -Expanding Provision of our Primary Mental Health Specialists (PMHS)	Primary Mental Health Specialists are already in place in parts of BNSSG: schools, school nurses, social workers, Early Help in Bristol, First Point in South Gloucestershire, GPs and Community Paediatricians have existing arrangements under their core offer. There are no Primary Mental Health Support workers in North Somerset, this is a significant service gap that needs to be addressed if we are to mitigate anticipated increases in demand. Demand for all existing PMHS services already significantly outweighs availability. This proposal seeks to build on this existing model to help meet the predicted increase in demand. OUTPUT: - Fund 6 new PMHS roles which will support a caseload of 60 children/young people at any one time (10 per WTE). This will be split between North Somerset (3 WTE), Bristol (2 WTE) and South Gloucestershire (1WTE), reflecting the current lack of service provision and likely demand. - PMHS professionals are highly skilled and very flexible in how they can be deployed. They are part of the specialist CAMHS teams and link with the wider community and other children and young people's organisations and services, including schools. - They will offer advice, specialist consultation and training to other staff who work with children, young people, their parents and carers. They can also work within the CAMHS clinics directly with children and young people and families. - This capacity will be allocated to the areas of BNSSG where there is greatest need.
Primary and Community Care: -IAPT waiting list initiative (10)	Additional funding would support the recruitment of an additional 20 clinical staff members (through agency) to treat those still waiting for assessment and / or step 2 and step 3 treatment. This would expedite the current trajectory from December 2020 completion to September 2020 to clear the waiting list from September 2019 to December 2019 and help to ensure the service can focus on referrals post January 2020 (including the covid-19 demand). To support our population during COVID-19 this proposal also suggests VHG introduce a non-core IAPT rehabilitation therapists (BASRAT) to help manage complex pain management interventions which deal with mental health issues related to persistent pain and provide a link between Physical and Mental healthcare. The BASRAT team will support a broad cohort of patients with Mental Health disorders and Long Term Conditions who could benefit from physical activity and psychoeducation support to aid their recovery from mental health conditions. The BASRAT team would also relieve the pressures within the core IAPT pathways as the intention is that individuals would either be directed down these pathways or have co-delivery of treatment and recover sooner. OUTPUT: 1. Accelerate and clear the WLI by September 2020

	2. Once the WLI has been cleared, VHG can concentrate solely on the waiting list incurred post-January 2020 and to manage additional referrals received as a result of COVID-19. 3. Accelerate the non-core IAPT BASRAT provision which is currently paused until January 2021 to provide complex pain management associated with Mental Health.
Crisis: -24/7 crisis line (27)	We need to ensure that people can quickly and easily access support. To aid this we are developing a universal-access, 24/7 BNSSG Mental Health and Wellbeing helpline. This will provide one telephone number for people in mental distress to use to quickly access the right level of support - to be available from mid-July. The line will perform four key functions: 1. Provide a first response for urgent mental health need and self-defined crisis. 2. Offer a therapeutic intervention with trained counsellors. 3. Provide a level of triage in order for people to receive the support they need. 4. Signpost people to appropriate community and statutory services.
Secondary/Specialist Care My team around me - enabling discharge and supporting clients at high risk of placement breakdown (12)	To commission a 12 month pilot to deliver the 'My Team Around Me' service. The service will provide intensive wraparound support to a cohort of 35 clients affected by mental illness. The service will provide intensive support to help clients maximise their independence and manage their recovery with support from a team of 5 support workers, working as part of a wider Multi-Disciplinary Team (MDT). The 35 service users will be people delayed in hospital and those within the community known to services who are at high risk of placement breakdown. This cohort will include a small number of people stepping down from the COVID-19 homeless hotel with a serious mental illness who are known to be high impact or high frequency users i.e. repeat attendances at ED, multiple inpatient admissions, repeat presentations at Section 136 Suite/ Place of Safety. Each support worker will hold a client caseload of 7 and will work with that individual on an ongoing basis.

Goal 6 – Workforce

Workforce solutions that have provided flexibility, mutual aid and integration as part of the Covid-19 response will be continued and developed further. Specifically there will be: (a) One system workforce approach, establishing appropriate governance to support an agile, system way of working across all parts of health and care, exploring dual hubs of resourcing and deployment to support all our services to be safe, resilient and supportive places to work. (b) Strong commitment to a joint Learning Academy, integrated with the Training Hub. (c) Continued consistency with our terms and conditions work, working together at a deeper level, including a "just culture" approach to employee relations. (d) Work together to recruit more people into health and care, drawing from the increased pool that has become available and maximise the positive

media perspectives on health and social care workforce and developing our Employer Value Proposition – including working with schools and colleges to promote health and care as a place to work.

In the light of the lessons learned and the collaboration we have forged during the Covid crisis, the Workforce Cell have identified five key workforce priorities for phase 3 as described in the goal above. The cell has also established a common commitment to drive Inclusivity and build a comprehensive wellbeing and development offer across BNSSG.

Four areas of focus to address these priorities with key actions are noted as follows and work is now underway to develop the local system response to the national People Plan issued in July 2020.

Area	Actions
OD and Engagement	**Equality, Diversity and Inclusion (EDI)** - summit on EDI, defining and delivering joint priorities, how EDI works across the patch.
	Engagement and wellbeing inc. psychological support
	Developing and delivering a **Talent development programme** for BNSSG
Learning Academy	The **passporting of Statutory/Mandatory Training** to reduce the repetition of unnecessary training and enable staff able to work across organizations.
	*** Schools & Colleges Engagement:** Develop a structure for schools and college engagement that ensures all young people within the BNSSG region have exposure to Health and Social Care career's activities, resources and placements. Develop a Young Persons pipeline that enables the smooth transition of young people from school/college and into the workforce through apprenticeships, traineeships and T-levels. The pathway will increase the diversity of the workforce by work with 3rd sector organisations, schools, colleges and local authorities.
	*** Apprenticeships:** Delivery of an STP wide Apprenticeship Strategy that will increase levy investment and provide direction on approach to further develop the apprenticeship offer within BNSSG
	Collaborate to procure a single **Learning Management System** across BNSSG to enable seamless sharing of all training records
	Develop **partnership working with education providers** to ensure that training and development aligns with the needs of providers and the system and establish the BNSSG Learning Academy and Training Hub as a clear gateway to coordinate the decision making process with local HEIs and FE sector
	Move towards the commissioning of education to support system objectives and working with HEE in developing and delivering the interim contract for **CPD provision** Manage resources collaboratively, ensuring appropriate assurance is in place to manage delivery of our system priorities
Supply and Demand	**Recruitment** - revise scope to include EVP, shared events inc schools and apprenticeships fairs and social care
	Develop a system approach to **student placements,** with input from the Place Based Placement Pilot and Nurse Supply Projects

	Voluntary workforce - linked to BCSE/Healthy Communities
	Nursing supply - joint approaches to increasing the supply pipeline including increased placements, international recruitment, preceptorship
	Retention Project - joint approaches to retention across the system based on best practice
	Supply and demand focussed in primary care including placements, support roles, newly qualified GPs, fellowships and the GPN 10 point plan
Workforce Modelling, Data and Metrics	**E Rostering** roll out across community using an interoperable system with acutes
	Robust workforce planning and modelling system impacts
	A workforce plan and training framework for **advanced clinical practitioners**

Goal 7 – Shared Data and Planning

System-wide data and capacity planning will underpin health and care provision in BNSSG, as seen throughout the Covid-19 response. Information on inequalities, and specifically the needs of BAME populations, will guide decision-making. This will ensure that shared and joint action allows the component parts of the system to work together seamlessly, resources to be kept agile and capacity to be flexible and aligned to need. A commitment to sharing data with the purpose of understanding system challenges, developing interventions and evaluation impact will be made by all partners

Delivery of this goal is owned by the Finance and Analytics cell which has been reviewing the core actions to be prioritised as described below to support health and care provision in BNSSG.

Area	Actions
Common data sharing agreement (DSA) agreed by all partners allowing data to be shared (inc. at patient level) for non-clinical purposes.	Draw up a DSA Set up a governance arrangement that is acceptable to all partners that oversees the purposes and/or use of the data e.g. annual approval for risk stratification; individual project approval.
Commitment to creation and population of a **shared data platform** accessible to all partners across Healthier Together.	Draft specification of the core requirements Review of existing platforms with capability to deliver
Agreement to sharing capacity information, alongside activity data, in terms of beds, budget, workforce, key equipment, estate etc. to enable a better understanding of productivity, utilisation & lost capacity due to Covid	Agree standard definitions of capacity Agree routine datasets to be collected and stored Draw up memorandum of understanding to define appropriate use, mindful of balance between system by default and commercial sensitivity
Have a refre**shed approach to capturing and using benchmarking data to drive change.** Ensuring visibility across the system of how our individual organisations compare to our respective peer groups across a suite of measures, with a particular	Identifying a core system group that can own both the inputs (data feeds from Model Hospital, RightCare etc) and the outputs in terms of analysis (both at an overview level for general understanding and at a detailed level in response to requests from change programmes etc). Creating a central repository (potentially on Future NHS

focus on understanding how benchmarking levels may have been impacted by Covid.	platform) to gather data and identify a long list of all key benchmarking sources and reviewing these to define an agreed suite of tools and measures to be regularly used in BNSSG to gauge system performance against peers.
One version of **system performance and the Outcomes Framework**	Detailed review of existing draft System Performance Framework and commitment to ongoing development and use. Proceed with procurement of Outcomes Platform

3. PART 2: National Phase 3 Planning Guidance

Headlines

The national Phase 3 planning letter as issued by Sir Simon Stevens and Amanda Pritchard on 31 July 2020 fulfils three main functions:

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

Priorities for Phase 3

The letter (see Appendix 1) describes the following priorities for the NHS for the Phase 3 period:

- 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.

Key headlines include:

- **EPRR incident level reduced from Level 4 (national) to Level 3 (regional)** on 1st August.
- **Restore full operation of all cancer services**. Restore referrals to pre-covid levels. Sufficient diagnostic capacity, increase endoscopy capacity, surgical hubs. Managing clinical priority and long waiters first.
- **Recover maximum elective activity before winter**. 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). Prioritise urgent patients, then longest waiters.

- **Restore service delivery in primary and community care**. Restore activity to normal levels, address child immunisations and cervical screening backlog, discharge from hospital and fully embed D2A. Resume CHC assessments from 1 Sept.
- **Expand MH services and LD+A.** resume IAPT. 24/7 crisis lines retained, CETRs, LEDER by Dec,
- **Prepare for winter** – IPC, testing, flu vaccinations, 111 first
- **Develop local response to the People Plan** to cover retention, support for staff, upskilling, recruitment, addressing inequality and numbers of staff.
- **Financial arrangements** to cover Aug and Sept. Rest of year tbc.
- **Comprehensive ICS coverage by Apr 2021**. Accelerate joint working. Single ICS leader and non-exec chair. One CCG per system by Apr 2021.
- **Summary Phase 3 Plan by 1 September**
- **Final Plans due by 21 September**

As summarised above, and as shown in Appendix 1, the letter contains many specific ambitions for the NHS such as restoring cancer services, recovering the maximum elective activity before winter, and expanding and improving mental heath, learning difficulty and autism services. Winter demand pressures are also expected to be significant, therefore Phase 3 planning also needs to focus on preparations for winter such as delivering a significant flu vaccination programme and working with local authorities to ensure resilience of social care. Significant focus is given to addressing health inequalities and notes the need to restore health services inclusively and accelerate prevention programmes that engage those at greatest risk of poor health outcomes.

The letter describes that the same financial arrangements as used from April to June 2020 are to be used for the period of July and August 2020 however a revised financial performance framework is expected following agreement with Government.

Following the Phase 3 planning letter as described above, further detailed guidance has been issued on 7 September 2020 which provides more detail on the requirements for this next phase.

4. BNSSG Approach to Planning

Objectives:

As BNSSG we have set ourselves the following key objectives which align with the national Phase 3 requirements. These are:

- Protect patient and staff safety
- Secure additional capacity where necessary
- Continue to flex capacity in response to COVID infection rates
- Maintain access to support for urgent needs
- Restore access for routine support where possible
- Respond to increases in demand for mental health support
- Minimise increases in waiting times

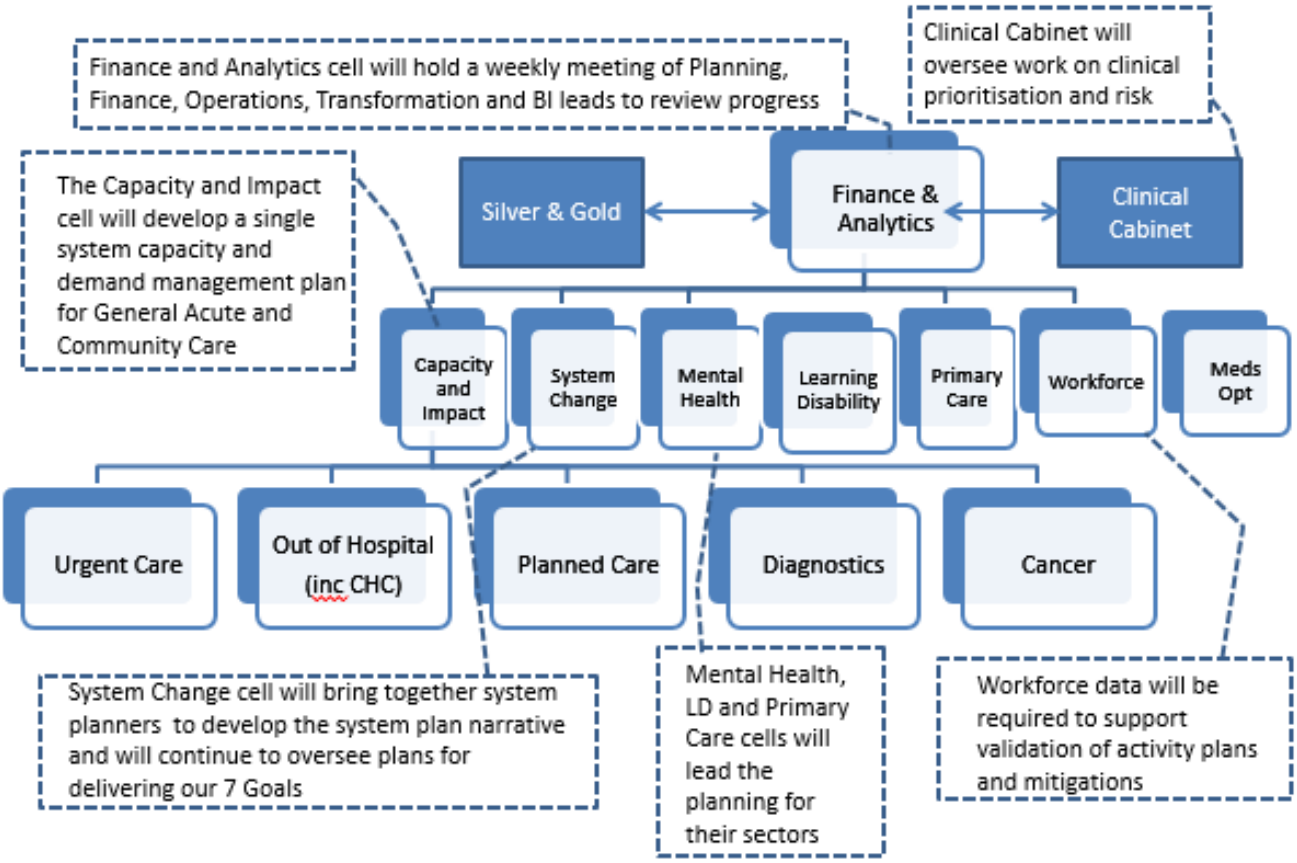
- Mitigate adverse impact on health inequalities
- Manage clinical risk at a system level where appropriate

BNSSG is now undertaking a rapid, Phase 3 planning process given there are challenging timeframes as set out below with the final national submission deadline 21 September 2020. Key areas being progressed relate to:

- Ongoing Covid scenario modelling
- Activity, workforce and performance planning
- Developing system transformation to support Phase 3
- Financial planning

System Oversight

Healthier Together Executive Group holds the overall ownership of Phase 3 planning at a system level with the Finance and Analytics Cell acting as a planning hub: coordinating the process and bringing people together to develop a coherent system plan. Key system groups supporting delivery include the Capacity and Impact Cell and System Change Command. Financial oversight is owned by system Directors of Finance and operational planning matters are overseen by Directors of Operations/Chief Operating Officers.



5. Covid Scenario Modelling

The scenario models for Covid in BNSSG are updated on a weekly basis to ensure as accurate as possible a view on the Covid-related demand over the coming months. Most recent modelling has taken into account factors including mandatory use of face masks and the expect return to schools of pupils from September onwards.

The scenario currently projected is based upon a reduction of (transmissible-potential) contacts to:

- 44.8% of the pre-Covid-19 levels from the 4th July 2020, and
- 45.2% of the pre-Covid-19 levels from the 24th July 2020, and
- 53.3% of the pre-Covid-19 levels from the 1st September 2020.

It should be noted that there are new cases of Covid present in the region however the demographic of those positive tests are somewhat different from when we were at the peak of cases and these are now more typically presenting as either non-symptomatic or pre-symptomatic patients who are not requiring hospitalisation.

Phase 3 planning leads continue to monitor this scenario modelling and to adapt plans as required to meet potential future demand.

6. Aligning Plans Across the System

The system is working collaboratively to ensure that we maximise the efficiency and value of services is BNSSG. A core part of the planning process is to develop activity, workforce and financial plans that best meet the needs of our population, align with national requirements, and are affordable. However activity planning as part of Phase 3 is unlike previous annual planning rounds as the system is required to plan under a number of new constraints such as a reduced bed base as a result of requirements around infection, prevention and control (IPC) guidelines and in the absence of a national financial framework that describes the flows of revenue and capital into the system. Nevertheless, through the Capacity and Impact Cell leaders from across the system are coordinating activities to ensure alignment of planning assumptions.

7. Submission Requirements/Templates

As described in the guidance documentation the following separate template submissions are required over the coming weeks

Submission/Template Name	National Submission Deadline
STP/ICS activity and workforce template inc. perf (template A)	1 Sept (draft) 21 Sept (final)
STP/ICS finance template (TBC)	TBC
Plan Narrative	1 Sept (draft) 21 Sept (final)
System level ‘Local People Plans’	21 Sept
Phase 3 Mental Health Planning support (template B in MH guidance)	Tab 3 due 12 Aug (cost pressures). 1 Sept (draft) 21 Sept (final)

Phase 3 Mental Health Finance (template C in MH guidance)	1 Sept (draft) 21 Sept (final)

A notable inclusion above is a required submission of system level 'Local People Plan', as requested in the national strategic plan, '*We are the NHS: People Plan 2020/21 - action for us all*'. This is being developed and coordinated by the People Steering Group in BNSSG and will align to the local sign off and submission processes are described above.

8. Key Milestones

The Phase 3 planning guidance requires plans to be submitted to NHSE/I by Monday 21 September 2020 with a draft submission required on Tuesday 1 September 2020. The timeline of key national dates is shown as follows.

Milestone	**Date**
Phase 3 letter issued	31 July
Guidance and template issued	7 August
Draft submission of the STP/ICS activity/performance and workforce templates. Draft submission of the associated STP/ ICS activity/ performance/workforce narrative commentary	1 September
Final submission of the STP/ICS activity/ performance and workforce templates. Final submission of the associated STP/ICS activity/ performance/workforce narrative commentary. Submission of system level 'Local People Plans'	21 September

The BNSSG system is working to ensure all local actions (including ensuring appropriate sign off on plans at both system and individual organisational level) are completed to meet these deadlines.

9. Financial resource implications

At the time of writing, there are still clarifications to be given from a national perspective to enable systems to complete the Phase 3 process – the most significant of these is lack of clarity around the national financial performance framework and the revenue and capital cost allocations that will be coming through to systems.

Capital Prioritisation Process

We have identified priorities for capital investment to increase capacity as a key mitigation against the demand and operational risks we face as a system for Phase 3. We submitted bids for c£167m of capital in July in response to requests from NHSE/I to illustrate the 'art of the possible'. We are now in the process of prioritising these schemes to maximise the impact of any additional capital allocations.

To date our providers have been allocated c£5.9m of critical infrastructure funding. In addition, DoFs have agreed to identify the quantum of local capital that has not already been committed and that could be reprioritised.

DOFs have proposed an approach to prioritising capital bids using a prioritisation matrix where the key factors seeks to identify bids that are:

- Deliverable in Phase 3
- Align with the LTP and 7 system goals
- Generate patient benefit
- Address health inequalities
- Contribute to a sustainable estate.

In addition the bids should link to system wide 'must have' requirements where we would face challenge if not progressed; be undeliverable within existing organisations due to budget constraints or system wide interdependencies; and be supported by appropriate clinical, financial and operational colleagues.

Bids are being captured by 14 August with a system 'star chamber' session w/c 17 August in advance of shortlisted schemes signed off by DOFs on 21 August and ratified by HT Exec Group on 24 August.

Risk Assessment

The uncertainty around the financial framework creates significant challenges for our health system in terms of being able to plan effectively and these have been captured in the following risks which have been developed through Finance and Analytics and signed off by Silver:

Description	Mitigations	Current Risk Score
As a result of delays in publication of NHS Financial Performance Framework and NHS and Local Government Covid **Revenue and Capital** allocations beyond Month 5 there is a risk that key decisions will be delayed which may result in either. (a) under preparedness for winter pressures and delay in Covid recovery phase. Or (b) financial decisions relating to Covid response taken at risk without an identified source of funding or cash.	Establish Phase 3 planning process to undertake as much preparatory work as possible, and identify priority areas for investment, including Clinical Cabinet System Restoration framework; and NHSE/I National Restoration Planning priorities. Prepare business cases and commissioning contract proposals (or initiate procurement) in advance of final agreement of funding. DoFs Draft Scheme of Delegation to take informed financial risks in a consistent way. SW Region led sessions on improving productivity. Maximise use of nationally funded resources, such as ISTCs. National and Region level lobbying. Re-prioritise existing capital programmes to meet Covid response priorities.	4x4=16
As a result of delays in publication of NHS Financial Performance Framework and Allocations beyond Month 5 there is a risk that **Allocated Transformation**	De-prioritise targets. Re-prioritise existing resources. Undertake advance business planning up to point of funding commitments.	2x3=6

Funding will not be available which may result in the system ability to meet Long Term Plan priorities, in particular mental health crisis and CAMHS; primary care transformation such as PCN OD & digital transformation; early diagnosis of cancer; Frailty/Ageing Well Programme	Follow Up with individual national programmes.	

10. Legal implications

The CCG has a statutory duty to operate within its resource allocation each year and to meet regulatory requirements as described by NHSE/I.

11. Risk implications

Key risks:

- **Timeliness.** As a result of the shortened planning period there is a risk that, as a system, we will not be able to complete all planning activities in a timely fashion which may result in BNSSG missing nationally stated planning deadlines. To mitigate this the key deadlines have been shared widely and timelines developed that ensure all activities are completed on time.
- **Affordability**. As a result of the lack of a national financial performance framework (unavailable at the time of writing) there is a risk that plans are not aligned and/or not affordable for the health system in the absence of clear allocations or funding streams for Phase 3. See section 10 above for further information.
- **Future Covid-19 peaks** – scenario modelling is updated on a weekly basis however there are significant risks to the stability of the system if there are future peaks of Covid-19, particularly if this occurs in the winter months where pressures on the NHS are already expected.

12. How does this reduce health inequalities

Covid-19 has particularly highlighted the need to focus on reducing health inequalities – particularly those inequalities that have arisen as a direct result of Covid-19. Phase 3 planning guidance has a key focus on the actions systems need to take to reduce inequalities. These include:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

13. How does this impact on Equality and Diversity?

There is significant diversity across our BNSSG population and any actions taken as part of phase 3 delivery need to be impact assessed – particularly when Covid-19 has been shown to have differential impacts on different populations groups.

14. Consultation and Communication including Public Involvement

The CCG's insights team have been running listening events with the public over recent months and findings are supporting the system's approach to phase 3 planning.

Appendices:

Appendix 1 – National NHS Phase 3 Planning Letter 31 July 2020
This can also be found at the following link:
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf

Glossary of terms and abbreviations

Please explain all initials, technical terms and abbreviations. .

	Where used abbreviations have been set out in full within the text.