NHS
North East London Commissioning Alliance

Questions from Members: Governing Body in Common meeting - part 1 - Wednesday 13 May 2020

Please note that some of these questions were responded to in the presentations to the meeting, some were answered during the live Q&A and others since, so please be aware that things may have moved on in some areas.

Questions submitted before meeting

Item 4.1 Covid response:
Q Will the work to understand mortality include the need to understand fully the level of deaths/excess deaths outside of hospital as well as the BME/inequality impacts?

A Yes - work has been commissioned by Public Health England (PHE) to look at all these aspects in relation to risk across various populations and communities, this is expected to provide some early findings by the end of May.

NB *report has now been produced and further inequalities workstream has been developed as part of NEL recovery and restoration programme.*

Q How will lessons be learned from the 'rapid discharge from hospital' process? What changes will be made to ensure that Covid spread is not exacerbated by the process?

A A number of evaluative approaches are being used to gather learning from the pandemic, including using academic health science networks. The Hospital at Home workstream already acts as a learning forum across NEL with representatives from each system. As part of the review of that work stream during May, a more consolidated assessment of lessons learnt will be available.

All patients are tested as inpatients and prior to discharge so homes know what care arrangements to put in place. Infection prevention control guidance and support for caring for positive patients has been provided both in terms of guidance and also as planned training to care homes staff. Where positive patients cannot be cared for in line with the guidance due to facilities constraints (i.e. not enough single rooms) then alternative arrangements can be made until patients are past the infectious stage of their illness. Where discharged patients Covid status is not known they will be treated within the guidelines for positive patients until their test result becomes available. There is significant guidance for the care home sector and this is regular reviewed as more information and evidence becomes available.

Q How will we ensure that the level of community rehabilitation/re-ablement services needed by discharged Covid patients is understood and resourced?

A We are using learning from national reviews of needs post Covid-19 to feed into assessments of need (including likely length of stay (LoS) in community beds) for both health and care. While the evidence is still being drawn together there is sufficient for us to begin to plan. This will happen through the SOCGs with assurance being provided to the ELHCP that appropriate actions are being taken.

Once we have finalised demand and capacity requirements for post Covid-19 care an assessment of new costs can be undertaken and funding identified and allocated. There is a NEL finance group in place already.

Item 4.2 Recovery:
Q How will the 8 tests be measured/ deemed to be met?

A We will produce three types of measure to assess against the 8 tests and 12 expectations. Firstly, any clear, measurable, metrics that fall out from the tests e.g. number of additional critical care beds. Secondly, key action areas for each workstream will be identified against the tests and reported on e.g. how are we delivering segregation in primary care? Thirdly, by working with patient groups to produce a series of "patient tests" so that we can explore the experience of any changes made to respond to the pandemic e.g. 'I am homeless, how will I access GP services?'

Each workstream and local system will be expected to produce a group of appropriate tests and monitor how we are doing against them.

The communications and engagement workstream is going to look at how we can work with local people/stakeholders to create the right patient tests.

Q Test 1 – Is segregation just in acute settings? What will happen in primary care/community services? How will it work for Social care/Care homes and hospices?

A Segregation is about all areas of service delivery. System Operational Command Groups (SOCGs) will be expected to demonstrate how segregation is being delivered in these community settings.

Q Test 5/6 – How will we achieve this without significant change in social care model? Is there any indication that this will be supported by DHSC?

A It is recognised that change will be required at all points in the system to a greater or lesser degree, and this is being worked through. We continue to work closely with our social care colleagues, and will be aligning this through the local systems work.

Q Test12 – Could you explain a bit about 'deliberative' public engagement?

A Deliberative engagement is where policy makers and the public come together to engage in constructive, informed and decisive dialogue about important and sometimes complex issues. One of the techniques used – and referred to by NHSE/I in respect of this plan - is citizen's juries. These usually include 12-14 randomly chosen people (who are representative as far as possible of local demographics.) They come together to deliberate a given issue and take place over a series of days (2-7). Participatory budgeting is another method used, whereby public participants in the exercise decide how to allocate part of a public budget. Some of our local authorities will have used this method before - Hackney certainly has in the past.

More information on deliberative engagement here:
https://www.involve.org.uk/resources/publications/practical-guidance/deliberative-public-engagement-nine-principles

We could use our NEL citizen's panel to conduct some deliberative exercises and we'd recommend engaging an independent research/engagement company to run these. This would just be one part of a far wider programme of engagement, where we would expect Healthwatch and our voluntary and community sector (VCS) to play a key role.

Item 5 Finance:
Q When will financial 'brakes' go on in terms of ending 'emergency' Covid funding? I.e. beyond month 4?

A We are expecting further guidance, but it is likely that we will be expected to live within the allocations already published, plus the additional funding for Covid that's been approved to date and will be planning on that basis

Q What is likely approach for 20/21 operating plan? E.g. continue with block contracts for acutes? How to deal with incremental costs in community?

A Formal guidance will be issued, but we're planning on the basis of block contracts for the full year 20/21

Q Will the independent sector be retained to help deal with the backlog of activity? What will cost be for NEL?

A Again – we are awaiting formal guidance but we've been advised that it will be retained in sectors where it is being utilised most effectively.

Q How will we build a future model which includes the incremental cost impacts of Covid on the system?

A This will depend on any national funding settlement the DHSC is able to negotiate with the Treasury.

Q What are the cost implications and capital requirements of Covid/non Covid and elective/non elective splits?

A The capital requirements are being worked through as part of our submission. It is very early in this assessment and we have a great deal more work to do to get this refined.

Q Will we continue with plans to devolve responsibility for specialised commissioning and how will its cost base be changed by Covid-19?

A Yes we will continue on that basis, although devolution to the ICS rather than to a CCG is the planning assumption (arrangements to be worked through). It is too early to understand how the costs will be changed but we are working on this now.

Item 2: Chair's Report: Our Staff: It is vitally important for all involved in keeping services running, and dealing with the pandemic, to be given enough time to rest and recover. Counselling, as required, should be considered (part of Test 5 and Test 8).

A From the start of the pandemic response the CCGs agreed that additional leave could be carried over but that it was recommended that staff take leave regularly to ensure appropriate rest and to support wellbeing of our staff. We have made a large range of online and telephone services available to support staff mental wellbeing, including access to counsellors and bereavement services. These make use of our existing Employee Assistance Programmes and a range of content being developed though the NHS England and Improvement. Wherever possible our approach is consistent with, or being rolled out to other NHS organisations across NEL.

Item 3: NEL AO Report: Single NEL-Wide Operating Model: I suggest that at perhaps the System Operational Command (NHS Response) level, one or more representative/s from the Nursing Home sector is/are included in the membership as a way to secure greater intelligence about the key issues and possible solutions. Going forward, such representation should be considered in the further development of ICS, and thus give Nursing Homes a higher profile and more attention as part of the ICS "Family".

A SOCGs have flexibility to bring in new members if required and to reflect the needs in their local system. We will also seek to work through existing local authority care home forums to ensure we hear their experience and what their needs are going forwards

Item 4.2: Covid-19 Recovery and Restoration Programme: Please include the excellent work that is emerging across NEL regarding Social Prescribing and Covid-19. This has a very important role in shielding, helping people in recovery from Covid-19, those with mental health issues, and children and young people. (I am actively involved as a Lay Member in this Steering Group).

A The important role that social prescribing has played in our Covid response is recognised. In particular the support that has been provided to some of more vulnerable population groups. The SOCGs in each of our Integrated Care Partnerships (ICPs) (BHR, C&H, WEL) will be leading the work on implementing multi-disciplinary team (MDT) working (which includes social prescribing) in their primary care networks (PCNs)/neighbourhoods, working closely with local partners including local authorities and the voluntary sector.

Item 5: Finance Overview: It will be very important to sustain the effort to reduce the historic underlying deficit in BHR. It has taken several years to reduce this to £8.4 million!

A This is recognised and reflects the strong partnership working between the NHS partners in the BHR system over the past 18 months.

Item 5.1: Financial Governance Covid-19:
Q Who will have the responsibility for ensuring that goods purchased meet the quality specification standards, and how will any "losses" be accounted for? (Example: As has happened with the disastrous procurement from Turkey!).

A We would expect goods available for direct purchase by CCGs and trusts to have appropriate quality or product certificates or assurances. Gowns and other highly critical disrupted supplies are currently being directly managed by the national procurement team and under their procurement control, responsibility for those items remains with the national team until such time as normal supply routes and volumes are available again.

AO's report - Q What are the plans for the retention of the many volunteers and retired doctors and nurses who have supported us during the pandemic when we move on to the Recovery Phase?

A Health and care staff have coped amazingly with sustained and high levels of pressure, that has been really helped by numbers of returning colleagues and with the support of volunteers and the third/ voluntary sector. As we move to recovery we will need to give colleagues a chance to rest and recuperate, at the same time ensuring Covid related work can continue and non-Covid work recover.

Returning colleagues and students are critical to the continued workforce available to support all of these challenges simultaneously, so trusts and services are encouraged to continue working with those returners as part of the wider team necessary to continue our response for patients in the medium term.

Volunteering and working with the third sector will continue to be critical, especially in supporting patients in the community and the most vulnerable who are shielding. Local authority colleagues in particular have identified that volunteering numbers may become lower once some people are enabled to return to work and are planning across London how to respond should that situation evolve. Work to identify those most needing support and the specific kinds of support they need is helping to ensure the volunteers we do have are able to be used in the most effective ways. The response of charities has similarly been amazing and we need to continue to work with them to understand what help they need to carry on supporting people as they have to date.

Questions during the meeting (Q&A) - summary

Q How do we ensure that every general practice is ready to test for Covid - swabs and antibody blood test and is ready for greater levels of flu vaccination and Covid vaccination when it becomes available?

A We understand that near patient testing is 4-6 weeks away and the national team will take the lead in managing the procurement approach.

Archna Mathur and Ceri Jacob will pick up preparations for flu, any available Covid vaccine via winter planning and primary care, we will ensure we link the Directors of Public Health in the planning too.

Q I'm struggling to see where patient and public involvement is positioned within this operating model, could that be explained please?

A We are developing a communications and engagement plan for recovery and Healthwatch, VCS and patient groups will be key to that. We want to develop our plans with our NEL Healthwatch colleagues and will be in touch very soon.

Q If we were to face a second wave, how will you implement plans; learnings from first wave. Will areas be prioritised? What have you done to prepare if second wave coincides with winter pressures, do we have a contingency plan?

A The response to Covid-19 has been more prolonged than incidents we have previously managed. Normally after an incident we would have a “hot” debrief for immediately learning, followed by a more considered “cold” debrief and formal after action review. These would help us capture learning and put measures in place in the event of future similar incidents. The pandemic response has been different in that we have had to repeatedly rapidly alter the way we work and then learn as we go. Some learning has been formal, others through sharing best practice in the various fora in which we meet regularly and some has been more formal via NHSE. Given the potential for future waves and that these may coincide with winter and the flu season we are planning now with NHSE how our response may need to adapt. The recovery and restoration planning process, in part, accounts for these variables and is a system plan to allow better coordination and resilience in the approach to managing multiple challenges simultaneously.

Q What are the NEL plans are for Contact Tracing, locally and system wide?

A This is being led through the local authorities and Directors of Public Health, who are currently waiting for further guidance

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882950/RGleave_letter_to_DSPH2.pdf

NB *– there have been further updates on this since, with further info on the Government’s Covid-19 web pages.*

Q We at Healthwatch Redbridge are very concerned that the discharge of patients to care homes is going to cause a massive increase in the risk amongst this group of vulnerable people, particularly when you consider patients are being discharged before tests are confirmed (for CV-19)

Next week, we will submit a report in which we identify concerns raised when surveying approximately 40% of care homes across Redbridge.

A We understand the concern about care homes. Please see response to the second question on page 1.

Q Can you elaborate on some of the engagement activities you have been having with local communities to reassure them it is safe to access NHS services for non-COVID interventions?

A We have shared the materials from the Government's new campaign about the NHS being 'open for business' and have been using the messages through our communications channels, but we will be doing much more as we know this is an issue. We are working with provider and local authority colleagues but welcome any suggestions. Healthwatch and VCS colleagues will be key here too. This is a major strand in our recovery plan and we are linking up with ICS communications leads in our planning.

Q What are we doing to support BAME staff and BAME patients?

A Our provider Trusts are undertaking risk assessments with their BAME staff using a risk reduction framework developed by the Faculty of Occupational Health Medicine and guidance provided by NHS Employers. They are at different stages of receipt and collation of information being collected as part of the risk assessment process, however this will be informing specific actions taken on an individual basis to support staff and more collectively in light of any consistent issues arising. They are also using their BAME staff networks to seek views on how best to support staff. Exploration is taking place as to how primary care providers are supporting staff. At a NEL level we are scoping a piece of work to collate our workforce data relating to impact on BAME staff recognising other vulnerability factors to take into account.

Each patient is individually assessed for their risk factors, including clinical and personal risk factors, as well as BAME considerations. There is work ongoing at a national level around all of the factors that affect mortality and morbidity. We will continue to update as we receive further guidance.

Q We're doing lots of engagement work with borough based partners with the local community, and are gathering invaluable insight which it important to feed into different parts of this structure. What's the best way to do this? *(questioner from Tower Hamlets)*

A That sounds really helpful. Please share this with the Head of Communications in WEL and also with the Director of Corporate Affairs for NELCA and we will make sure that is seen by SMT and relevant leads – we will get back to you with info on how it is being addressed.

Q - In recovery and restoration are we planning to use volunteers? I would like to see us capitalising on this social capital that the pandemic has generated. I would like to see volunteers used really imaginatively rather than the traditional confined roles that they have often occupied. Also developing a skills bank, some of our volunteers will have really useful skills and experiences from their other lives.

A The response of volunteers and the third sector has been central to supporting particularly the most vulnerable groups affected by the response to Covid-19. The NHS Apps, charities and the banks of volunteers that local authorities are able to tap into do record the skills that various volunteers can bring

to the response, as such we would not seek to create a separate skills bank but work closely with those who have existing and enduring ways to mobilise the incredible way volunteers have and continue to contribute.

Q What is the Patient Involvement Group and who's on it? What are its terms of reference?

A - This will be new and we will share details as plans are developed, however working with local Healthwatches will continue to be a key element of our engagement.

Q Can you circulate a list of membership of each of the SOCG Boards?

A The SOCG's include senior CCG, NHS provider and local authority representatives as core members. The details are held within each of the three local integrated care partnerships.

Q Can we be assured that the changes that have been made at speed without any consultation will not just be continued by default. David Sloman's report about the future of London NHS suggests that changes can only be ditched with permission

A We have made every effort in this emergency to inform and engage with patients, the public and their representatives. We have met with patient groups and others wherever possible to ensure there has been a good flow of information.

We anticipate being in this emergency for another year or so. Arrangements will be kept under review as we respond to the pandemic and ensure that we keep patients safe for any non-Covid treatment or procedures. We will continue engaging and surveying patients to ensure services meet their needs and we will pay particular attention to marginalised groups in society to ensure that services are accessible and of high quality.

In this emergency it is absolutely essential that whilst local (e.g. north east London) systems try to restore services for many patients who have had their urgent treatments on hold, that we do not undo the capacity and capability that might be required pan-London in the event of any second wave of Covid. The mutual aid provided by each system to take patients, provide supplies and equipment has been instrumental in helping the NHS cope with the pandemic and we can't yet reverse any changes that might still be needed in the emergency.

We will ensure that we follow any legally required engagement and consultation processes.

Q Are detailed plans on Care Home and Community capacity being developed at each of the three system levels. When will they be visible?

A Yes, plans are being developed and Local Authorities will submit these to central government on 29 May.

Q it would be helpful to have some assurance that the reduction in the underlying deficit at the three BHR CCGs be maintained and reduced further despite the pressures that will come from the recovery and restoration phases...

A BHR CCGs had planned on delivering a surplus during 2020/21 and therefore clear its remaining deficit, however due to the emergency finance arrangements put in place by NHS England, no CCG for the period to 31 July 2020 is permitted to deliver a position other than break-even. The expectation is that once the emergency finance arrangements are lifted, BHR CCGs will revert to its original operating plan assumptions and look to deliver the investment and savings aspirations it set itself at the beginning of the year. This will be impacted by the timing of recovery and restoration plans, but there remains scope to identify opportunities that deliver a surplus in the current year and beyond.

Q On Financial Governance, and regarding procurement for and within the NEL system, who will have the responsibility for ensuring that goods purchased for corvid-19 meet the quality specifications, and how will any “losses” be accounted for?....citing the issues regarding the purchases from Turkey....

A There are a number of response teams working in NEL and with NHSE to ensure equipment acquired is appropriate and fit for purpose. In addition, Covid-19 financial governance arrangements have been put in place and agreed by the governing bodies to ensure controls are maintained.

Q The GP@hand use/spend raises concerns re access?? We are really in a strong position re access across WEL, especially during pandemic the response has been phenomenal from PC. Any reflections/comments?

A Two observations. Firstly I agree that the shift to non-face to face has indeed been a massive effort, and secondly, I believe that patients will stay with their local practices is they can receive quality and timely attention, which we will need to maintain in the future.

Q What impact, will additional costs such as PPEs have on existing contracts and financial position?

A There are a number of short term arrangements in place to support additional Covid-19 costs. These include block contracts with ‘top up’ arrangements for NHS providers, additional cost recovery procedures for CCGs and links with Local Authorities to review additional discharge related costs on a monthly basis. Other direct purchase costs may be incurred at a local level, or are centrally coordinated through NHS England teams