Humber Health and Care System

Operational Plan 2020-21

Version 5.0 (**DRAFT**)

Contents

Section 1:

Executive Summary

About the Humber

Our Ambition

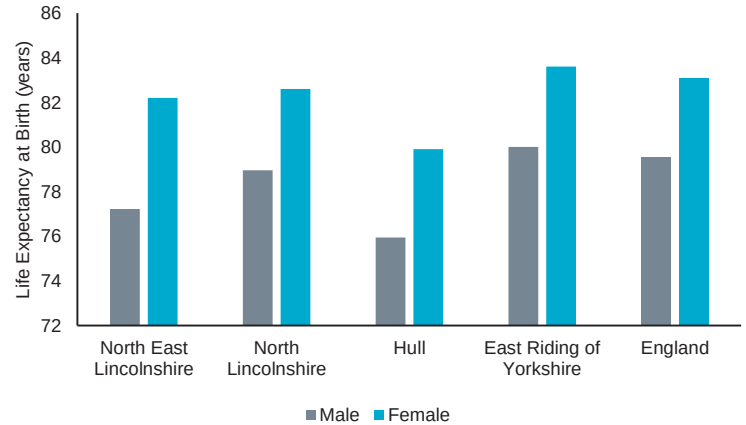
To deliver a recovery plan which supports health and wellbeing across our population, with a focus on addressing health inequalities which have been exacerbated as a result of the C-19 outbreak and response.

To achieve this, our existing ambitions to support people to stay physically and mentally well and manage their conditions in community settings must accelerate, prioritising those who are most at risk, clinically and socially.

Humber Facts

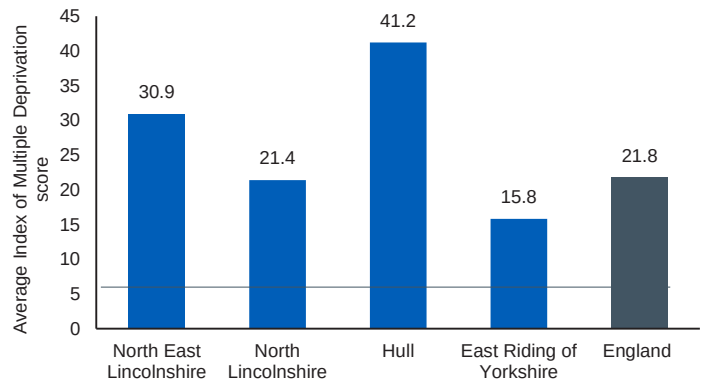
- 21 different organisations and 17 Primary Care Networks (PCN's
- 919,600 projected population 2026
- The population is ageing with the number of people aged 65+ growing considerably faster than younger age groups
- North East Lincolnshire and Hull are within the top 20 most deprived areas in England. Averages mask significant areas of socio-economic deprivation in North Lincolnshire and the East Riding

Age - The average age in the Humber is 42



Source: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2015to2017

Deprivation



Source: Department of Communities and Local Government (DCLG)

Our Priorities

Our Issues

- Providing ongoing care and treatment of COVID-19 cases, including post-COVID care and maintaining availability of surge capacity
- Operating within reduced capacity across health and social care due to the impact of infection minimisation and other policy responses
- Managing the consequences of the system response to COVID-19, including:
  - deferred and delayed care
  - impact on system performance (list size and waiting times
  - missed prevention opportunities
  - healthcare-avoiding patient response

Our Response

- Identify and support the most vulnerable, including work to address health inequalities
- Identify people who are at risk of becoming mentally and physically unwell and providing integrated care and support within communities to avoid hospital admissions
- Develop primary, community and mental health capacity, services and workforce to safely manage higher volumes and higher risk patients
- Maximise the use of available acute capacity, prioritising patients at the highest risk
- Capitalise on innovations introduced during the immediate COVID response

Plan Overview 1

Sector	Deliverables	Outcomes
Primary Care	• **Network DES** - Advanced Health and Care home service, structured medication service and medication optimisation • **Cancer** – Early Cancer Diagnosis service • **Screening and immunisation** • **Learning Disability and Severe Mental Illness health checks** • Primary Care Offer - embedding shift to **Total Triage and online service offers**	• 100% of care homes in receipt of enhanced offer. • 10% reduction in ambulance conveyances and admissions to hospital from care home • Increased screening programme participation rates. • Improved flu vaccination uptake. • Increased health check coverage. • Reduced demand for face to face primary care services.
Community Care	• **Integrated frailty mode**l of targeted, proactive, interventions to include prevention, proactive support and crisis management Rapid access for community and primary care to **specialist support and advice from Respiratory Physicians** Delivery of **Care Homes DES** across primary care - Enhanced community care homes model • Sustaining the COVID-19 **Hospital Discharge Service** Requirements	Frailty • 10% reduction in non elective admissions • 10% reduction in conveyance • 10% reduction in non elective admission Respiratory - 10% reduction in admissions Care Homes • 10% reduction in ambulance conveyance • 10% reduction in non-elective admissions • 10% reduction in ED attends. Discharge • Increase number of home first discharges • Increase number of same day discharges • Improve DTOC position and reduce readmissions of complex cases
Learning Disability and Autism	• Maintain **digital offer / re-introduction of face to face appointments** • Complete recruitment and establishment of **Forensic Outreach Liaison Service** • Development of **Positive Behavioural Support Service / Academy** • Reinstate / Introduce **preventative activities** • **Safeguarding and CETR**	• Increase number of LD physical health checks (ref. Primary Care section) • Reduce waiting times for autism assessment through (majority) online methods • Prevention of falls, obesity and worsening of existing health conditions • Support to carers to respond to any enhanced requirements and engagement of carers via digital means to support rehab for individuals

Plan Overview 2

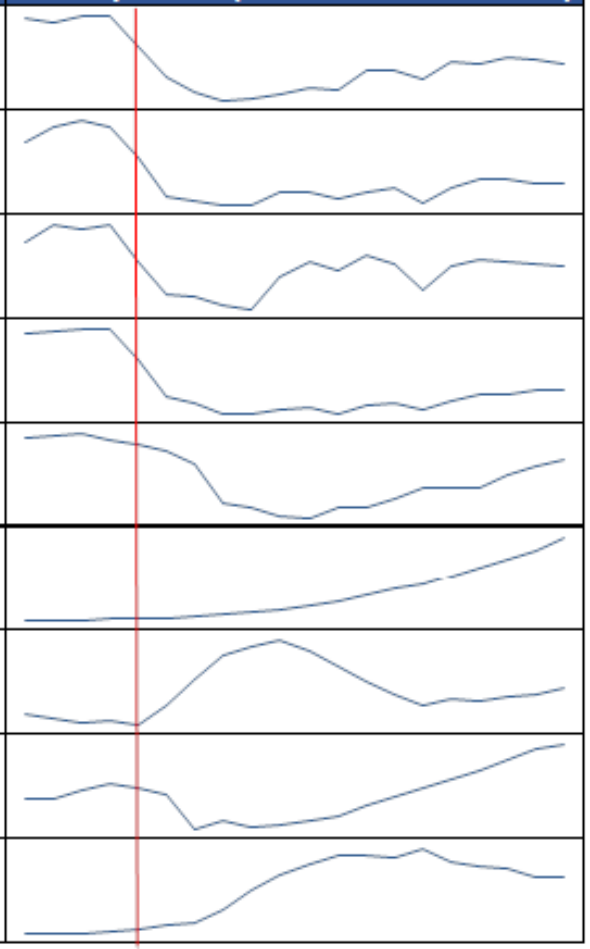
Sector	Deliverables	Outcomes
Mental Health	• Manage the **IAPT Surge** • Maintain the **Crisis Response** • Manage the **Psychological Impact of C19 on the population** • Support to **Children and Young People** • Continued delivery of the **Mental Health Long Term Plan** • Increase number of **SMI physical health checks** (ref. Primary Care section)	• Reintroduction of face to face support • System approach to workforce support and development implemented • Joint approach between health and local authorities to supporting children, young people and their families • Crisis and IAPT services may experience poorer outcomes (waiting times and access) without additional resources
Acute Sector	• **Clinical triage** of referrals and deployment of advice and guidance, streaming straight to test etc • Embedding **remote consultation** by both telephone and video • **Clinical validation** of patients awaiting follow up and moving patients to patient-initiated follow-up pathways or discharge with results • **Radiology review of diagnostic requests**; redirection to lower invasive tests where appropriate • Clinical prioritisation processes that **target resource at highest priority cases** • Use of **independent sector capacity**	• Safe and effective management of clinical risk within capacity constraints • Capacity retained to cover Covid admissions, including in critical care, to accommodate May 2020 levels of activity and have a surge plan that can accommodate 150% of the first peak

Section 2:

Assessing the Performance Impact of COVID-19

Impact of COVID-19 on Performance – Planned Care

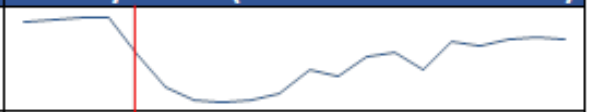
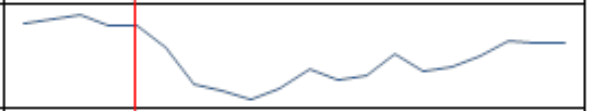
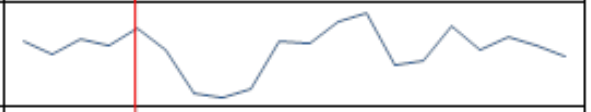
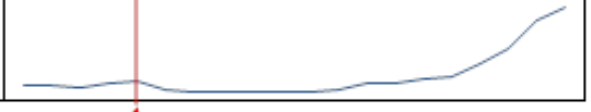
Sector	Measure	Baseline	COVID Impact	% Change	Weekly Trend (17th Feb to 29th June)
Planned Care	GP Referrals	3,802	1,515	-60.1%	
	New outpatient attendances	7,406	3,982	-46.2%	
	Follow up outpatient attendances	15,762	11,589	-26.5%	
	Elective daycase and inpatient admissions	2,804	1,179	-58.0%	
	RTT list size	78,035	78,965	1.2%	
	52 week breaches	9	2,324	25722.2%	
	Follow up backlog	50,079	53,379	6.6%	
	DM01 List Size (NLAG Only)	13,632	15,776	15.7%	
	DM01 6+ Week Breaches	3,254	12,899	296.4%	



Baseline and COVID impact based on snapshot pre-COVID and end of June 2020

Baseline and COVID impact based on average week

Impact of COVID-19 on Performance – Cancer Pathways

Sector	Measure	Baseline	COVID Impact	% Change	Weekly Trend (17th Feb to 29th June)
Cancer Pathways	2ww Referrals	665	424	-36.3%	
	2ww Appointment attendances	736	430	-41.5%	
	2ww Seen within 14 days %	95.4%	91.6%	-4.0%	
	62 day RTT Cancer Performance %	64.0%	64.1%	0.1%	
	62 Day PTL Backlog (NLAG Only)	192	170	-11.5%	
	104+ PTL Backlog (NLAG Only)	31	98	216.1%	

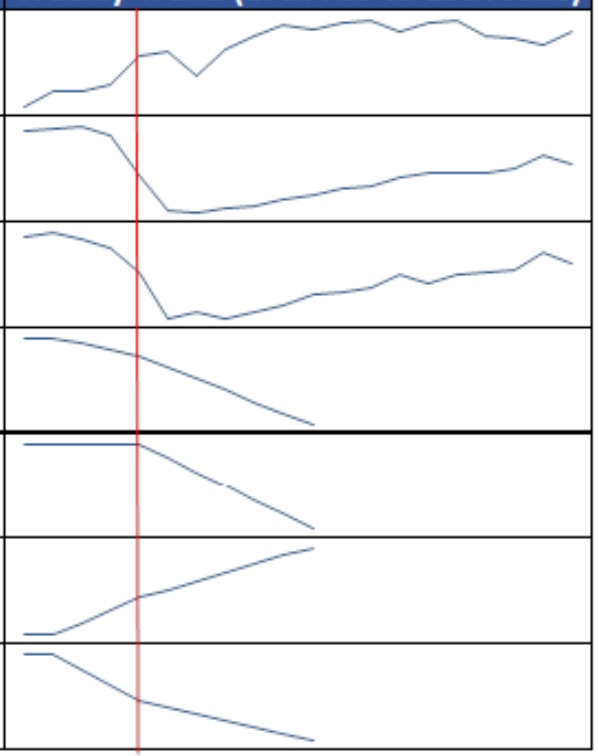
Baseline and COVID impact based on snapshot pre-COVID and end of June 2020

Baseline and COVID impact based on average week

March 23rd (Beginning of Lockdown)

Impact of COVID-19 on Performance – Urgent Care

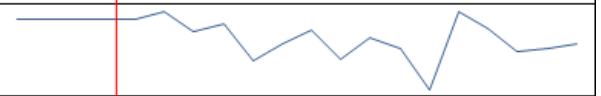
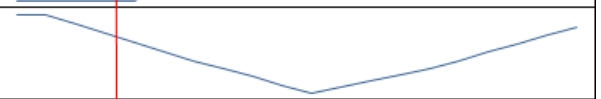
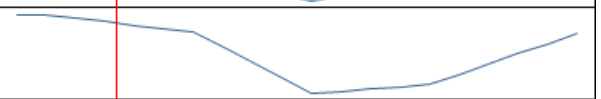
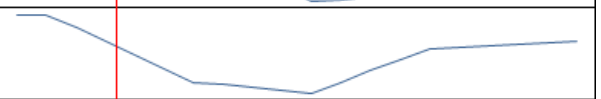
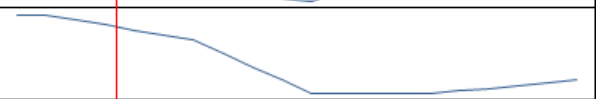
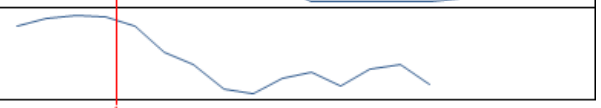
Sector	Measure	Baseline	COVID Impact	% Change	Weekly Trend (17th Feb to 29th June)
Urgent & Emergency Care	4hr Performance (All Types) %	80.1%	90.6%	13.0%	
	Number of Attendances (All Types)	7,257	4,823	-33.5%	
	Emergency admissions	1,829	1,336	-27.0%	
	Ambulance Calls (NL & NELCCG only)	1,300	1,045	-19.6%	
	Ambulance Hear & Treat (NL & NELCCG only)	173	111	-35.9%	
	Ambulance See & Treat (NL & NELCCG only)	177	262	47.6%	
	Ambulance See & Convey (NL & NELCCG only)	709	564	-20.4%	



Baseline and COVID impact based on snapshot pre-COVID and end of June 2020

Baseline and COVID impact based on average week

Impact of COVID-19 on Performance – Mental Health/Primary Care

Sector		Measure	Baseline	COVID Impact	% Change	Weekly Trend (17th Feb to 29th June)
Mental Health	IAPT	IAPT Referrals Level	100.0%	41.7%	-58.3%	
		IAPT Contacts Level	100.0%	90.0%	-10.0%	
	Home Treatment	Adults Home Treatment Contacts Level	100.0%	214.6%	114.6%	
	Carers	Carers Support Contacts Level	100.0%	402.2%	302.2%	
	Inpatient Bed Occupancy Rates	Adult Acute	91.5%	72.8%	-20.4%	
		Older Adult Acute	97.1%	72.6%	-25.3%	
		Adult Eating Disorder	99.5%	83.0%	-16.6%	
		Secure	77.7%	67.9%	-12.7%	
Primary Care		General Practice Appointments	97,351	65,530	-32.7%	

Baseline and COVID impact based on snapshot pre-COVID and end of June 2020

Baseline and COVID impact based on average week

March 23rd (Beginning of Lockdown)

Section 3:

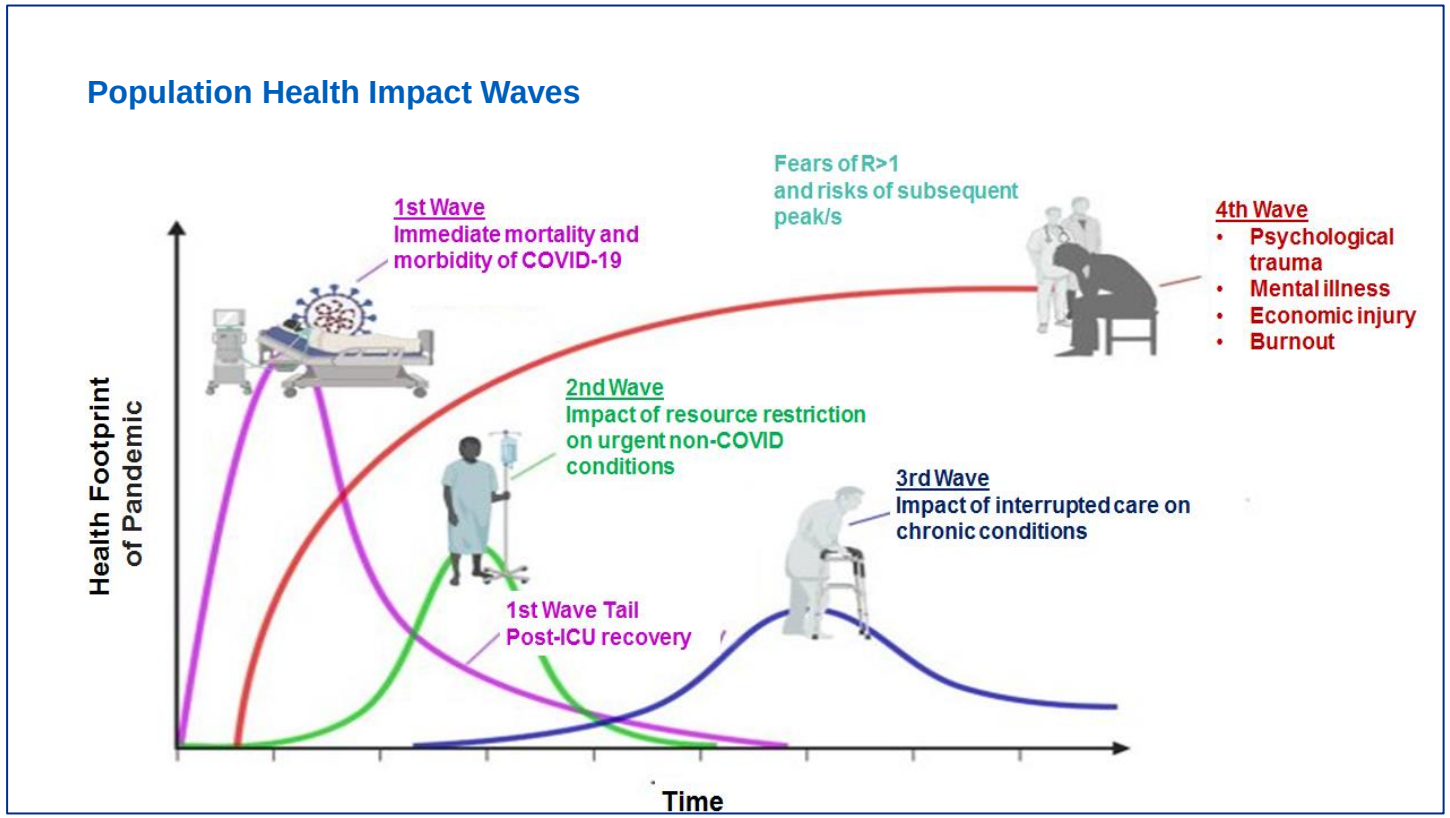
Assessing the Population Health Impact of COVID-19

Assessing the Impact on our Population

Our plan uses a Population Health Management (PHM) approach based on Impact Waves to identify groups within our population who will be the most vulnerable during the COVID recovery period.

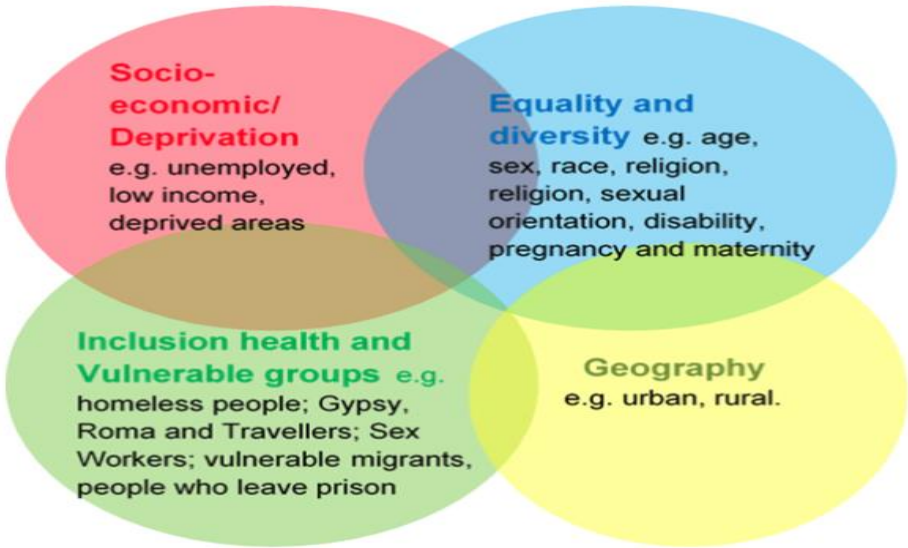
Initial findings indicate the direct and indirect impacts of COVID disproportionately affect already disadvantaged communities:

- Excess COVID infection and mortality among BAME groups and people living in disadvantaged areas.
- Reduced access to healthcare is likely to affect disadvantaged communities more acutely
- Economic threat, mental health worries due to lockdown and educational disadvantage all threaten the poorest and most marginalised communities the most.
- Children and young people will be one of the groups most affected.



Humber EQIA

Approach



Royal College of Physicians model

Initial Findings

- Significant BAME impact – higher mortality + highlighting & exacerbating pre-COVID inequalities
- Hearing access can be affected by mask wearing
- Impact of lockdown measures on disabled people
- Access to accessible info for people with learning disabilities, national reports and assurance needed on DNARs
- End of life impact - faith groups
- Toll on mental health + reduced access to services
- Pregnancy and maternity – loss of shared milestones during pregnancy
- Gender inequality:
  - Significantly higher mortality for males
  - Impact on women includes stress of taking greater household and caring responsibilities
  - Financial inequalities heightened
  - Gender based violence increased

Key Groups

Low income families / food poverty

SEND and at-risk children

Victims of Domestic Abuse

C-19 Shielded Groups

BAME communities and workforce

People and carers over 70's

People with existing mental health problems

People experiencing mental health and psychological issues

Marginalised Groups – refugees, migrants

People with addictions

People with LD and Autism

Supporting our Population

Supporting the whole population the stay well is crucial to addressing the long term health and wellbeing impact of the COVID outbreak and response as well as for managing demand for health and care services. It will also be crucial to design services to address the needs of vulnerable groups, within the community and close to where they live whenever possible

Helping our Population to Stay Well

- Maintaining uptake of vaccinations and immunisations, including flu.
- Restarting cancer screening and encouraging uptake:
- Campaigns promoting appropriate access routes for health services, e.g. Talk before you Walk models
- Engage with local communities to understand how public attitudes and behaviours have changed in relation to accessing healthcare
- Recognising and promoting the role of the voluntary sector in supporting our population to stay well

Addressing Health Inequalities

- Accelerating existing programmes to address longer term, pre-covid health inequalities e.g. prevalence and impact of CVD, early diagnosis of cancer
- Working with Places to accelerate existing work to address the wider determinants of health

Supporting Vulnerable Groups

- Volunteer hub and community/voluntary sector support for vulnerable people, including shielding groups
- Access to social prescribing for marginalised, vulnerable and isolated groups
- Health checks for people with learning disability and severe mental illness
- Access to carers support teams for frail and complex patients and their carers.
- Address backlogs and manage expected surge in services for vulnerable children and young people, including SEND
- Support digital inclusion and maintain non-digital access routes to avoid excluding vulnerable groups
- Work with Active Humber to support people who are disproportionately affected by the pandemic to access sport and physical activity
- Work with the Voluntary and Community Sector, individuals and their families to develop community resilience
- Work with local authority and VCSE to offer support to households in food poverty

Supporting our Children and Young People

Children and young people will be one of the groups most affected by the COVID outbreak and response. A co-ordinated response is required to avoid long term harm to vulnerable children and young people.

Segment	All children and young people	More vulnerable	Increased need	Special educational needs and disabilities
Issue	Missed appointments, routine vaccinations or health service	Delivering an integrated Early Help offer to help, protect and reduce inequalities for more vulnerable children. Identifying more vulnerable children and providing universal and targeted help. Ensure safeguarding measures are in place and effective, recognising that some institutions (e.g. schools) will not be able to provide the same level of service	Emerging emotional health, well-being and mental health concerns, anxiety, trauma and life changing experiences. Supporting children with Education Health and Care Plans (EHC) and who are otherwise identified as vulnerable Negative experiences of children in care. Children who have been subjected to harm, abuse and exploitation-including Hidden Harm	Reducing the lengths of time children and families wait for assessment and services
Action Required	Reviewing missed vaccinations, promoting access including digital (see Primary Care delivery plan). Supporting schools and child care settings with protective measures and attendance	Promoting the multi-agency system and role of early help across the health and social care arena. Information sharing across all agencies	Stepped up and additional capacity considered to reduce current waiting lists. Specialist therapeutic intervention. A key focus upon transitions is essential to join the provision up and reduce young people falling through the gap. See Mental Health delivery plan.	Neurodiversity assessment and provision of services. See Learning Disability and Autism delivery plan.

Section 4:

Our Delivery Plans

Section 4a:

Primary Care

Primary Care Summary

Challenges and Opportunities	Key Deliverables /Priorities
• Managing long term conditions within primary care, including managing patients with higher acuity • Role of PCNs in implementing PHM approaches to identify and support vulnerable groups • Reinvigorating vaccination, immunisation, screening and health check programmes • Reduced estate capacity due to social distancing and COVID-related working arrangements in light of COVID e.g. Hot sites and requirements to wear PPE/cleaning	• Network DES implementation • Cancer • Improving Screening and Immunisation rates • Additional workforce through Additional Roles Reimbursement Scheme • LD and SMI Health Checks • Primary Care Offer - embedding shift to Total Triage and online service offers
Resource Requirement	**Risks**
• Primary care workforce development was paused pre-covid and will be re-commenced as part of recovery. • Expanded and diversified primary care workforce (Additional Roles Recruitment Scheme). • Delivery of the Flu work may require some additional investment to deliver innovative solutions given the expected expanded eligible cohort	• Potential impact of track and trace on staff absences • Patient engagement with digital services – behaviour changes may have been temporary due to COVID and previous behaviours may return. • Impact of COVID re social distancing limit service delivery capacity. • Workforce plans across organisations/sectors will need to be joined up to avoid the expansion of roles in PCNs negatively impacting other parts of the system.

Demand and Capacity in Primary Care

During the COVID-19 response period, **numbers of appointments in primary care declined** due to:

- Patient driven reduction in demand due to COVID
- Standing down of some routine primary care activity to reduce face to face appointments
- Working arrangements in light of COVID e.g. Hot sites, PPE/cleaning
- Social distancing requirements reduce capacity of premises

Demand is increasing again through Phase 3 due to the following factors:

- Patients grow in confidence to utilise
- Routine work increases as part of recovery phase
- Other parts of system re-commence and impact upon demand in primary care
- Implementation of Network DES

Capacity will also increase during Phase 3 through:

- Changes in working practices and management of Hot / Cold activity
- Bringing extended access capacity back in to the system (some has been stood down/reduced)
- PCNs recruit additional roles in primary care

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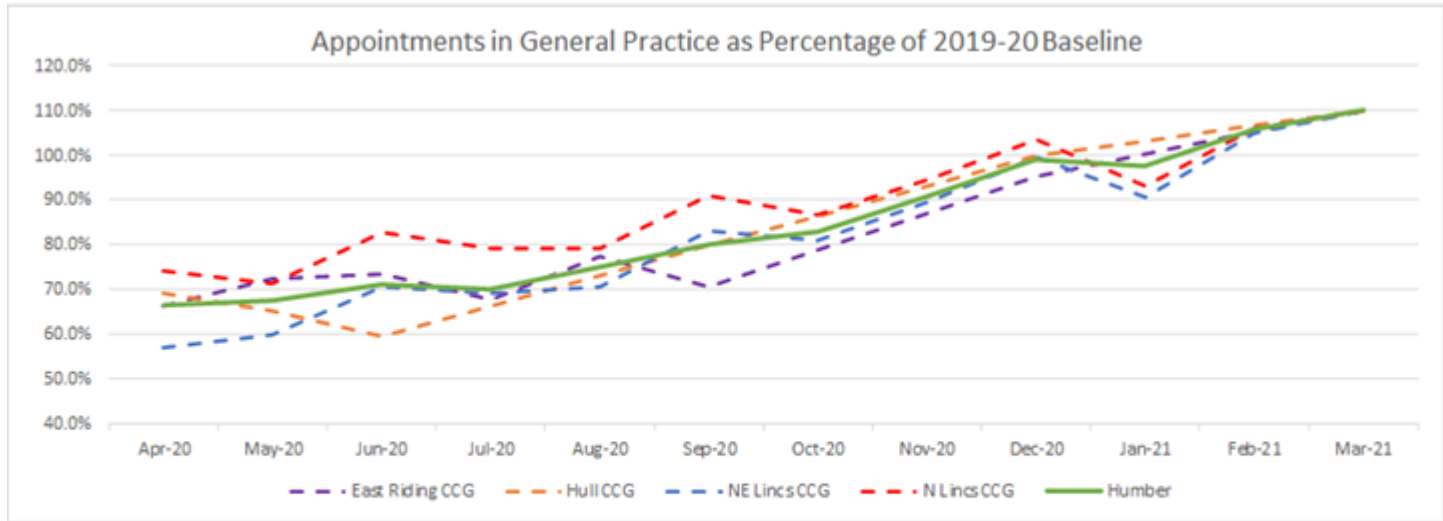


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total
East Riding CCG	82,548	84,531	87,147	89,763	92,379	94,995	123,385	121,659	118,549	141,075	128,005	136,929	**1,300,965**
Hull CCG	75,540	72,940	64,215	80,336	76,705	94,534	117,314	111,546	108,657	128,792	119,502	129,072	**1,179,153**
NE Lincs CCG	51,251	54,424	60,467	66,894	60,099	76,174	86,549	81,329	80,451	86,438	86,529	89,671	**880,274**
N Lincs CCG	61,144	61,233	66,369	72,869	62,789	82,789	91,606	86,981	84,236	86,979	87,826	95,847	**940,668**
Humber Total	**270,483**	**273,128**	**278,198**	**309,861**	**291,972**	**348,492**	**418,854**	**401,515**	**391,893**	**443,284**	**421,862**	**451,519**	**4,301,060**

Primary Care Delivery Plan Summary 1

No	Key Deliverables /Priorities	Q2	Q3	Q4	Impact Measures and Timescales	Delivery Risks
1	**Network DES** Advanced Health and Care home service, structured medication service and medication optimisation	• COVID-19 Care home support model in place	• Enhanced Health in Care Homes service being delivered • Structured Medication Review and Medicines Optimisation being delivered	• Agreed volume of SMRs being delivered	• 100% of care homes in receipt of enhanced offer • Contribution with other community initiatives to an estimated 10% reduction in ambulance conveyances and admissions to hospital from care home • Agreed volume of SMRs being delivered	
2	**Cancer**	• Delivery of Early Cancer Diagnosis service specification • Participation in national audits	• Lung health check service restored		• Up to 40 low dose CT scans per day • Screening programme participation rates - screening programme to be determined by each PCN; RDC utilisation	PCN capacity to deliver requirements. Screening programme and RDC delivery may be impacted by ongoing COIVD situation. Capacity of mobile CT scan unit and radiology. Return of respiratory staff to the lung health check service
3	**Screening & Immunisation**	• Review of uptake position for range of programmes and flu	• Screening programmes delivering and flu vaccination being delivered		• Flu vaccination uptake rates for priority groups: improve by X%	Patient engagement with services. Impact of COVID re social distancing limit service delivery capacity. Expected expansion of eligible population for flu programme. Availability of facilities in primary and community care

Primary Care Delivery Plan Summary 2

No	Key Deliverables /Priorities	Q2	Q3	Q4	Impact Measures and Timescales	Delivery Risks
4	**Workforce**	• PCNs workforce plans developed and CCG support in place supporting recruitment • incremental increase in workforce	• Recruitment plans implemented		• PCN progress in delivering ARRS posts: ER PCNs: 29; Hull PCNs: 29; NL PCNs: 17; NEL PCNs: 17	PCN progress in delivering ARRS posts: ER PCNs: x; Hull PCNs: x; NL PCNs: x; NEL PCNs: x
5	**LD & SMI health checks**	• Review of performance and development of support required to deliver	• Workforce support (SMI)through CMHT in place		• LD Annual Health Check trajectories: ERY: 84.8%; Hull: 49%; NEL: 34.8% NL: 75.1%. SMI: ERY: 15% ; Hull 60%; NEL: 33.3%; NL: 60%	Patient engagement with services. Digital exclusion of people with a LD may make achieving AHC trajectories challenging
6	**Primary Care Offer - embedding change**	• Humber wide engagement with patients & public regarding changes to service delivery in primary care July/Aug • Humber wide online services campaign • Understanding of views of patients and public to changes and impact for particular groups	• New models of care delivery - including Total triage and self-care - embedded within primary care • IT investment to support new models of care - primary care digital investment plan • Patient/public awareness of online service availability • Increase in utilisation of online services	• Impact of embedding total triage models: - Increased resilience; - Improved access; - Time to care - for those patients that need it most; - Improved satisfaction for both patients and staff; - Improved efficiency		Due to the demand returning to normal and potentially increasing, General Practice may return to previous models of delivery. Patient behaviour may have been temporary due to COVID and previous behaviours may return. Positive changes may not have had sufficient time to be embedded. Potential impact of track and trace on staff absences.

Section 4b:

Community Care

Community Care Summary

Challenges and Opportunities	Key Deliverables /Priorities
• Challenges in managing long term conditions within community care, including managing patients with higher acuity • Supporting vulnerable and at risk patients in the community, through an integrated community care offer. • Mitigating and responding to the care homes market position including mutual aid and capacity plans in escalation • Delivery of Care Homes DES across primary care - Enhanced community care homes model • Maintaining safe, supported discharge from acute.	• Implementing a frailty model of specialty reactive response and support Humber wide • 10% reduction in non elective admissions across the Humber for frailty cohort • Delivering rapid access for community and primary care to specialist support and advice from Respiratory Physicians • 10% reduction in admissions for identified respiratory cohort • 100% care home residents with individualised and advanced care plans. • Increase in care home residents achieving preferred place of care at end of life
Resource Requirement	**Risks**
• Multi disciplinary health and care workforce • Digital solutions including information sharing and COPD tele-monitoring • Specialist clinical support for frailty, palliative care and respiratory services • Investment in sustaining voluntary sector support to community hubs for shielding community • Social care support to carers and respite options • Secure funding for Community Response Team GP 8-8 service from 1st Oct 20. • Expansion of pulmonary and community rehabilitation services	• Market stability in care home and home care sector and care workforce impact - recruitment and retention - the sector may be viewed as more risky and less attractive • Workforce availability. • Embedding cultural change within a short timeframe. • Access to specialist capacity from within acute trusts • Delivery is reliant on improved interfaces and relationships between care homes and health services.

Community Care Delivery Plan Summary 1

No	Key Deliverables /Priorities	High Level Milestones	Impact / Key outcomes (SMART)	Impact Measures and Timescales	Delivery Risks
1	Integrated frailty model of targeted, proactive, interventions to include prevention, proactive support and crisis management	Q2.Complete baseline of capacity and resource in each place to implement principles of Hull frailty pathway across the Humber Determine single point of access for A&G in each place	Q2.Reduction in emergency admissions	Q2. Sustained 10% reduction in non elective admissions for over 80 yrs in Hull & ER	Availability of redesigned workforce to mobilise model, particularly in places where service is less developed. Requires significant engagement within a short timescale to deliver culture change across all system partners, embedding ownership across all provider organisations.
		Q3.Single point of access/contact and coordination in hours and at peak times out of hours in place for each place Personalised individual care planning process operational across health and care	Q3. Increase in ambulance non conveyance rates following advice to paramedics from frailty response line and provision of home based interventions.	Q3. 10% reduction in conveyance across the Humber for frailty cohort	
		Q4.Model of specialty reactive response and support Humber wide	Q4. Reduction in non elective admissions	Q4. 10% reduction in non elective admissions across the Humber for frailty cohort	
2	Rapid access for community and primary care to specialist support and advice from Respiratory Physicians	Q2.Establish baseline of community respiratory services across Humber Agree pathway changes	Q2. Humber wide plan to deliver rapid response to COPD patients at risk of admission	Q2.	Reliant on capacity within acute trusts to transition to deliver on outward facing model within a short timescale.
		Q3. Identify COPD patients most at risk of admission	Q3. Extend COPD cohort	Q3. Extend Hull COPD cohort from 100 to 400 patients	
		Q4. Provide A&G and MDT response 7 days a week from specialist MDT	Q4. Reduction in admissions for identified cohort	Q4. 10% reduction in admissions for identified respiratory cohort (Humber wide)	

Community Care Delivery Plan Summary 2

No	Key Deliverables /Priorities	High Level Milestones	Impact / Key outcomes (SMART)	Impact Measures and Timescales	Delivery Risks
3	Delivery of Care Homes DES across primary care - Enhanced community care homes model	Q2.Named clinical leads in primary care identified & co-ordination of the multi provider approach for all care homes	Q2.Named leads in place for care homes	Q2. 100% of care homes have named lead	Care homes staffing capacity. Reliant on delivery of improved interface and relationships between care homes and health services. Capacity in primary care to deliver full enhanced care homes offer.
		Q3. Integrated enhanced care homes offer in place. Enhanced community care homes model - progressing the EPaCCS (electronic end of life record).	Q3. Primary care will ensure individualised and advanced care plans are in place for residents. Increase in residents achieving preferred end of life place of care	Q3. 100% Residents with individualised and advanced care plans. Increase in residents achieving preferred place of care at end of life	
		Q4. Implement IPC training across all care home providers. Escalation routes for all Infection Prevention and Control concerns in line with local outbreak plans. Enhanced care homes offer fully mobilised.	Q4.Reduction in infection rates and care home staff sickness. Reduction in ambulance conveyance to hospital, ED attends and non-elective admissions.	Q4. Reduction in infection rates tbc. 10% reduction in ambulance conveyance to hospital of care home residents. 10% reduction in non-elective admissions. 10% reduction in ED attends.	
4	Sustaining the COVID-19 Hospital Discharge Service Requirements	Q2. Review cost and impact of retaining a funded discharge model.	Q2. Same day / next day ambition Notification of discharge for complex discharges by 2pm for discharge the following day	Q2.Increase number of home first discharges Increase number of same day discharges	Timescales for discharge & safe transfer when package of support is required; the 3 hr target could undermine a Home First ethos Funded discharge model reliant on continued investment
		Q3Timescales for discharge reset in light of complex discharges where a coordinated and safe package of support is required implementing D2A and TA models	Q3. System wide services are available 7 days a week TA forms reviewed	Q3.Improve DTOC position and reduce readmissions of complex cases.	
		Q4. integrated discharge and a focus on trusted assessment and out of hospital re-assessment operational	Q4. Joint Health and social care approach with the priority being people needs are reviewed daily	Q4.Meeting DTOC targets Reduced number of MFFD patients in acute settings	

Community Bed Demand and Capacity

- Our primary focus across Phase 3 continues to be **supporting individuals to return to their usual place of residence**. However, access to flexible step up / step down care plays a role in supporting rapid discharge and preventing admissions.
- The initial COVID response provided insights into the **requirement across the Humber for a flexible responsive community bed base** which can be mobilised to respond to increased infection rates and surges in demand.
- A **review of the Humber community bed base** is planned during Phase 3 to clarify our future community bed base requirement.
- Throughout Phase 3, we aim to **maintain the majority of the current commissioned bed capacity** the current level
- The **split between hot and cold sites** is expected to continue
- East Riding Community Hospital will continuing as a hot health site (30 community beds with piped oxygen and enhanced medical support)
- 12 hospice beds representing potential additional hot capacity that could be scaled up in case of a second wave.
- Support for care homes to manage infection control internally and flex up hot and cold beds
- The majority of the other sites will be cold sites

Summary of Bed Capacity/Utilisation by Bed Type

Bed Type	Declared Beds	Used Beds	Declared Vacancies	Utilisation Rate
General Residential	4,078	3,421	657	83.9%
Dementia Residential	3,043	2,646	397	87.0%
General Nursing	706	554	152	78.5%
Learning Disability Residential	580	524	56	90.3%
Mental Health Residential	380	326	54	85.8%
Dementia Nursing	206	181	25	87.9%
Transitional	94	75	19	79.8%
Mental Health Nursing	73	64	9	87.7%
Community Care	71	48	23	67.6%
YPD - Young Physically Disabled	65	57	8	87.7%
Adult Inpatient beds	43	32	11	74.4%
Community Rehabilitation	30	21	9	70.0%
Learning Disability Nursing	27	22	5	81.5%
Children's Inpatient beds	3	3	0	100.0%
Grand Total	**9,399**	**7,974**	**1,425**	**84.8%**

This table shows a snapshot of community bed capacity at 09/06/20

Community Care Stepped Up Case Digital Technology

Additional funding requests have been submitted for two projects to deliver enhanced technology in care homes. These projects will support delivery of the full enhanced care homes offer and care homes DES.

Project Title	Description	Capital Funding Required 2020-21	Benefit Summary
Electronic Care Home Monitoring (Independent Providers)	Electronic care monitoring system in independent residential settings to provide a real time overview of residents 24/7	£1,050,000	• Increased information sharing ability cross the system • Person centred approach to recording and a customer focused journey for the resident • Real time data and intelligence to enable identification of patterns and risks
Technology in Care Homes	Technology to support care homes and their residents to access remote consultations, communication with loved ones; additional support and activities currently being rolled out remotely across the sector.	£1,500,000	• Minimise unnecessary visits to care homes by GPs and other professionals • Clinical support from a distance, improving the physical well-being of residents whilst supporting effective care • Additional and improved contact with family and friends, reducing social isolation and improving mental well-being • Access to a wide range of online activity materials, improving physical and mental well-being

Section 4c:

Learning Disability and Autism

Learning Disability and Autism Summary

Challenges and Opportunities	Key Deliverables /Priorities
• Digital working has largely proved to be very successful e.g. facilitated engagement of individuals who have been difficult to engage on a sustained basis previously and missed appointments have decreased • Opportunity to explore how physical health checks are undertaken e.g. remote check. Would need to consider how physical measurements are captured and advocacy issues. • Proactive and preventative health promotion groups / activities have been stood down leading to worsening of conditions/ increased falls and risk of needing secondary care intervention • Suspension of services for ALD leading to impact on carers and their respite and possible threat to placement breakdown when not addressed • Safeguarding issues may rise / have been suppressed	• Maintain digital offer alongside re-introduction of face to face appointments where they are assessed as being needed, but address digital exclusion – digital literacy +/- deficit of infrastructure. • Increase number of LD physical health checks (ref. Primary Care section) • Reduce waiting times for autism assessment through (majority) online methods • Complete recruitment and establishment of Forensic Outreach Liaison Service • Reinstate/ introduce activities to prevent falls, obesity and worsening of existing health conditions including activities out of hours to provide weekend respite • Development of Positive Behavioural Support Service / Academy • Support to carers to respond to any enhanced requirements and engagement of carers via digital means to support rehab for individuals • Develop proposal for safe spaces • Risk stratification of safeguarding concerns
Resource Requirement	**Risks**
• Investment in Helios digital autism assessment system – will require capital investment. • Capacity within primary care to undertake increased numbers of LD physical health checks • Digital equipment and infrastructure for end users and carers – will require capital investment	• Impact of latent demand on workforce availability • Lack of capacity within the community resulting in increased inpatient activity and/or out of area placements • Capacity to deliver physical health checks for people with LD • Underlying challenges around autism assessment and diagnosis waiting times

Learning Disability and Autism Delivery Plan Summary

(for LD Health Checks please refer to Primary Care section)

No	Key Deliverables /Priorities	Q2	Q3	Q4	Impact Measures and Timescales	Delivery Risks
1	Maintain digital offer / re-introduction of face to face appointments	Re-establish face-to-face monitoring by case managers of individuals in inpatient settings	Re-Introduce programmes of intensive rehab in community to address increase/deterioration in health conditions	Develop / respond to insights from people with lived experience	Whilst use of MS Teams etc. has enabled case managers to maintain contact with patients face to face visits will enable more proactive monitoring of placements to ensure safety and quality	Recurrent funding for digital solutions / platforms may not be available
2	Development of Positive Behavioural Support Service / Academy		Develop model based on best evidence	Agree model / develop business case	Supporting care providers to deliver care underpinned by the principles of Positive Behavioural Support will reduce episodes of behaviour which challenge, increase quality of life and reduce admissions	
3	Reinstate / Introduce preventative activities	Re-establish day activities and develop out of hours provision to provide structure to daily living which has been lost during lockdown Maintain STOMP / STAMP	Develop / respond to insights from people with lived experience Maintain STOMP / STAMP	Develop / respond to insights from people with lived experience Maintain STOMP / STAMP	Prevention of placement and family breakdown Prevention/reduction of falls, obesity and worsening of existing health conditions Re-engagement with core rehab provision including AHP provision and psychological therapies Reduced demand on Intensive Support Teams and prevent carer crisis and placement breakdown	Individuals may be fearful of re-engaging
4	Safeguarding and CETR	Risk stratification and prioritisation of safeguarding issues – for CYP coinciding with school restart. LeDeR case reviews	Continue prioritisation of safeguarding issues Establish single point of contact and pathway from CETRs on North Bank LeDeR case reviews	Continue prioritisation of safeguarding issues LeDeR case reviews CETR/CTR Hub approach	Safeguarding issues addressed. Individuals with CETR plans, and their families / carers, are supported through a whole system approach. Reduces admissions. Learning from LeDeR case reviews	Inability to manage ‘Surge’ in suppressed demand.

Section 4d:

Mental Health

Mental Health Summary

Challenges and Opportunities	Key Deliverables /Priorities

• Over 5 years the number of additional episodes for people with a diagnosable MH condition who need help from any part of the system are:
  • Children and Young People – 52%
  • Working age adults – 23%
  • Older People (65+) – 22%
 	
Note: These figures represent episodes therefore the number of individuals will be lower.
	• Manage the IAPT Surge
	• Maintain the Crisis Response
	• Manage the Psychological Impact of C19 on the population
	• Support to Children and Young People
	• Continued delivery of the Mental Health Long Term Plan
	• Increase number of SMI physical health checks (ref. Primary Care section)

Resource Requirement	**Risks**
• 24/7 Humber wide crisis line – will require investment. • Increase staff productivity with technology and process improvements – will require capital investment. • Social distancing measures will lead to increased estates requirements – will require capital investment. • Investment in Phase 3 for proactive schemes which tackle demand/capacity early • Proactive risk assessment of the most vulnerable staff and proactive MH outreach support to health/social care workers – will require investment. • Adaptation/expedition of Long Term Plan requirements to focus in on C-19 recovery, including current funding gaps at Place	• Impact of latent demand on workforce availability • Lack of capacity within the community resulting in increased inpatient activity and/or out of area placements • Capacity to deliver physical health checks for people with SMI • Capital and recurrent revenue investment to support capacity, transformation, productivity and process improvement may not be available • Lack of recurrent investment will likely increase demand in other sectors

Mental Health Demand and Capacity

Challenges

- IAPT referrals reduced by 50% for March – May 2020, equating to potentially 4,068 supressed referrals. Backlogs are likely to result in longer access to treatment times
- Change in prevalence and demand relating to COVID could see a 6% increase on the population with a common mental health disorder.
- Acuity is increasing in mental health acute due to the suppression of lower level referrals in mental health services (such as IAPT): by the time patients present they require very intensive home treatment or admission.

IAPT	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total
	Activity						
Expected service users entering treatment (Pre COVID amount) Service capacity is prepped to receive these service users	1810	1810	1810	1810	1810	1810	**10860**
Additional Suppressed (60% of total - percentage of service users that won't drop out before first appt and will enter treatment)	205	409	614	820	1025	1025	**4098**
Additional COVID Related Anxiety/Depression (60% of total - percentage of service users that won't drop out before first appt and will enter treatment)	182	182	182	182	182	182	**1092**
Additional Whole Time Equivalent (WTE)							
Extra IAPT Capacity needed for Region to conduct Suitability Assessments	0.38	0.75	1.13	1.5	1.88	1.88	**7.5**
Extra IAPT Capacity needed for Region to offer Step 2 treatment (40% of service users having more than 2 appointments at step 2)	0.47	0.93	1.40	1.86	2.33	2.33	**9.30**
Extra IAPT Capacity needed for Region to offer Step 3 treatment (60% of service users having more than 2 appointments at step 3)	1.13	2.26	3.39	4.52	5.65	5.65	**22.6**

Demand and Capacity in Inpatient Mental Health

Challenges

- Increased acuity will increase length of stay, resulting in pressures on bed occupancy, particularly shown below where occupancy equals or exceeds 100%. Work is ongoing to address this scenario.
- Social distancing/isolation wards will likely increase bed pressures in MH leading to increased out of area placements

Activity		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Bed Occupancy Adult Acute	Occupied Beds	2812	2439	1898	2245	2657	3143	2926	2855	2884	3032	3305	3261	3265	3424
	Available beds	3075	3287	3060	3162	3060	3503	3163	3060	3162	3060	3534	3534	3332	3689
	Occupancy (%)	91.45%	74.20%	62.03%	71.00%	86.83%	89.72%	92.51%	93.30%	91.21%	99.08%	93.52%	92.28%	97.99%	92.82%
Bed Occupancy Older Adult Acute	Occupied Beds	1662	1613	1031	1146	1553	1538	1538	1499	1538	1809	1896	1961	1820	1647
	Available beds	1711	1829	1770	1829	1770	1790	1772	1710	1767	1710	1767	1767	1597	1767
	Occupancy (%)	97.14%	88.19%	58.25%	62.66%	87.74%	85.92%	86.79%	87.66%	87.04%	105.79%	107.30%	110.98%	113.96%	93.21%
Bed Occupancy PICU	Occupied Beds	214	240	201	208	203	209	209	203	209	251	259	259	235	259
	Available beds	290	310	240	248	240	248	248	240	248	300	310	310	280	310
	Occupancy (%)	73.79%	77.42%	83.75%	83.87%	84.58%	84.27%	84.27%	84.58%	84.27%	83.67%	83.55%	83.55%	83.93%	83.55%
Bed Occupancy CAMHS Tier 4	Occupied Beds	109	211	188	196	202	209.25	302	292	302	292	302	302	273	302
	Available beds	145	279	270	279	270	279	403	390	403	390	403	403	364	403
	Occupancy (%)	75.17%	75.63%	69.63%	70.25%	74.81%	75.00%	74.94%	74.87%	74.94%	74.87%	74.94%	74.94%	75.00%	74.94%
Bed Occupancy Eating Disorder Adult	Occupied Beds	202	169	156	192	191	152	147	173	193	210	217	217	196	217
	Available beds	203	217	210	217	210	217	217	210	217	210	217	217	196	217
	Occupancy (%)	99.51%	77.88%	74.29%	88.48%	90.95%	70.05%	67.74%	82.38%	88.94%	100.00%	100.00%	100.00%	100.00%	100.00%
Bed Occupancy Secure	Occupied Beds	1352	1530	1475	1522	1519	1519	1612	1620	1736	1680	1674	1674	1512	1674
	Available beds	1740	2077	2250	2325	2250	2325	2325	2250	2325	2250	2325	2325	2100	2325
	Occupancy (%)	77.70%	73.66%	65.56%	65.46%	67.51%	65.33%	69.33%	72.00%	74.67%	74.67%	72.00%	72.00%	72.00%	72.00%
Bed Occupancy Locked Rehabilitation	Occupied Beds	174	186	180	186	180	185	185	180	185	180	185	185	170	185
	Available beds	206	216	210.83	215.83	210.83	215.83	215.83	210.83	215.83	210.83	215.83	215.83	200.83	215.83
	Occupancy (%)	84.47%	86.11%	85.38%	86.18%	85.38%	85.72%	85.72%	85.38%	85.72%	85.38%	85.72%	85.72%	84.65%	85.72%

Mental Health Delivery Plan Summary: Base case (1)

No	Key Priorities	Q2	Q3	Q4	Impact Measures and Timescales
1	Maintaining the Crisis Response	Complete build of second S136 suite (HTFT only) Reintroduce face to face interventions Mobilising enhanced adult crisis service through the use of pre-allocated NHS England monies (RDaSH only) Engage in consulting with staff about Core24 alternative model (RDaSH only)	Ambulance/Patient Transport initiatives such as MHERV in North East Lincolnshire. Explore opportunity for enhanced VCS offer; and enhanced home treatment model of care to reduce inpatient need/demand (RDaSH only) Implement alternative core24 model (RDaSH only)	Crisis Home Treatment and Liaison Services –scoping exercise and linkages with developing urgent care model “talk before you walk” Move routine assessments from the Assessment & Liaison team into the newly formed PCN MH Team to release capacity to focus on urgent and emergency care (RDaSH only) Develop model for a 24/7 home based treatment service (RDaSH only)	Demand will exceed capacity resulting in poorer outcomes, ‘default’ to Primary / Secondary Care services and existing Crisis services. Waiting times will increase. Increased face to face interventions will support those who are digitally excluded
2	Supporting Children and Young People	Collaborative and co-ordinated response provided for young people, families and school staff returning to the school setting Kooth online counselling platform to be monitored and evaluated Maintain a digital first model for consultation and group work. Health / Local Authorities collaborate through one offer i.e. through children’s centres; other stakeholders to continue joint delivery of group work. Continue to offer eClinic functionality within School Nursing and initiate within CAMHS services (RDaSH only)	Consistent assessment offer for young people with eating disorders or neurodevelopmental challenges CAMHS PICU opened for intended purpose and no longer providing U18s isolation area (HTFT only) CAMHS Tier 4 services reintroduce visiting of families and home leave reinstated (HTFT only) Increase presence in schools for Neurodevelopmental, School Nursing and Vaccination & Immunisation services.	CYP MH Whole pathway commissioning pilot implemented Multi-agency approach to neurodevelopment assessments Agree definition for CYP home treatment; 0-25 years; Mental Health Support Teams for 2021/22	Key performance indicators will continue to deteriorate: - Waiting times from referral to start of treatment (length of wait) - Number of patients waiting for the start of treatment (waiting list) - Average and longest waiting times - Care Programme Approach (CPA) formal annual reviews compliance will likely reduce Quality outcomes impact tbd Pathways will be aligned to the “Thrive” delivery framework

Mental Health Delivery Plan Summary: Base case (2)

No	Key Priorities	Q2	Q3	Q4	Impact Measures and Timescales
3	IAPT Surge	Increased productivity through use of digital therapies Using digital to full effect expanding the appropriate use of groupwork. Talking Shop open to walk in referrals (RDaSH only) Use virtual clean clinic model or equipment loan model to support those virtually excluded (potential once modelled), with preferential face to face appointments where required (RDaSH only)	Target recruitment capacity at reducing step 3 waiting lists. Workforce planning	Improved recruitment rates supported by flexibility to work from home Consolidation and rationalisation of estate informed by new digital working practices Continued reduction of wait for step 3 treatment. Agree workforce model and investment for 2021/22 and mobilise recruitment and training action.	Key performance indicators will continue to deteriorate: -Waiting times from referral to start of treatment (length of wait) -Number of patients waiting for the start of treatment (waiting list) -Average and longest waiting times -Care Programme Approach (CPA) formal annual reviews compliance will likely reduce Quality outcomes impact tbd Increased face to face interventions will support those who are digitally excluded
4	Psychological Impact	Implementation of real time proactive monitoring for suicide prevention. Focus on vulnerability / inequality to allow prioritisation / risk stratification Ref: Workforce Plan initiatives	Full face to face restoration of priority areas with accelerated new normal mapping.	Workforce / service planning	Mitigate impact on health inequalities In conjunction with other priorities, mitigate escalation to crisis, psychological services, inpatient admissions and broader system impact e.g. primary care, social care, A&E.
5	Long Term Plan	CMHT / PCN transformation recommenced Recruitment to all vacant CMHT posts commences Introduce system based on risk/patient choice for undertaking memory assessments using remote assessments as primary option IPS recovery plan completed and implementation begins	CMHT / PCN transformation implemented Recruitment to all vacant CMHT posts continues	CMHT / PCN transformation implemented Recruitment to all vacant CMHT posts continues IPS recovery plan ambitions achieved	Demand into Primary Care supported by redesign of CMHT with specific resource aligned, mitigating escalation. Reinstate / increase number of people having memory assessment and utilise a digital option where appropriate.

Mental Health Delivery Plan Summary: Stepped Up case (1)

(Note: Stepped Up Case assumes all Base case actions / impacts are undertaken and benefits realised)

No	Key Priorities	Q2	Q3	Q4	Impact Measures and Timescales	Delivery Risks
1	Maintaining the Crisis Response	Maintain voluntary sector support into triage service 8 - 8.30, 7 days per week Maintain Mind 24 hours advice support and signposting Redeploy CAMHS, Early Intervention and neuro staff to support the ED streaming Approved business case for all age SPA & Crisis Resilience Hub Recruit additional care navigators for PCN integration.	Recruitment of specialist practitioners and CAMHS support workers to ensure continuation of 24/7 CAMHS Crisis Support Introduction of an Intensive Home Treatment team to the CAMHS Crisis service Agree sustainable model for ED streaming in alternative location to the acute hospital Establish 24/7 support to the ED streaming service from voluntary sector partners Integrate NEL & NL to single Humber-wide Crisis & Resilience Hub Implement Core 24 to complete Humber-wide Core 24 Service (NEL only)	Continuation of Q3 Complete SPA and Crisis Hub integration to HUFT, & NYY Plans	Supports response to the anticipated 'surge' in CAMHS, Older People's Crisis Services, Adult MH services and Liaison Services	Additional investment of circa £1.4m with significant associated recruitment
2	Supporting Children and Young People	Introduce Upstream Engage to support group interventions Maintain Eating Disorder Clinic collaboratively with acute trust	Established process for providing full specialist neuro assessments of ADHD and Autism remotely Consistent offer in place for ways to assess young people with eating disorders or neurodevelopmental challenges	Established scope for providing 7 day CYP Contact Point via merged teams across Hull and ERY Introduce collaborative front door services with MIND and East Yorkshire LA Child Psychological Wellbeing Practitioners and Early help	Key performance indicators will improve: - Waiting times from referral to start of treatment (length of wait) - Number of patients waiting for the start of treatment (waiting list) - Average and longest waiting times - Care Programme Approach (CPA) formal annual reviews compliance will likely reduce Quality outcomes impact tbd	Additional investment of circa £0.5m with significant associated recruitment

Mental Health Delivery Plan Summary: Stepped Up case (2)

(Note: Stepped Up Case assumes all Base case actions / impacts are undertaken)

No	Key Deliverables /Priorities	Q2	Q3	Q4	Impact Measures and Timescales	Delivery Risks
3	IAPT Surge	Existing estate is optimised to enable effective social distancing and IPC requirements Develop digital response plans for digital therapies and wider Silvercloud access including roll out of Silvercloud self-registration to GP websites Increased productivity through use of digital therapies	Remote group therapy introduced via Upstream Pathway for Long Term Conditions developed collaboratively with Primary Care and acute sector Recruitment plan agreed with partners Increased productivity through digital technologies to deliver digital response plans. Develop and test new digital pathways and protocols.	Implement new digital pathways and protocols. Develop and implement peer support groups to aid recovery and manage long term, conditions. Improved recruitment rates supported by flexibility to work from home and our digital offer Consolidation and rationalisation of estate informed by new digital working practices	Key performance indicators will improve: -Waiting times from referral to start of treatment (length of wait) -Number of patients waiting for the start of treatment (waiting list) -Average and longest waiting times -Care Programme Approach (CPA) formal annual reviews compliance will likely reduce Quality outcomes impact tbd	Additional investment of circa £0.35m with considerable associated recruitment
4	Psychological Impact	Providing proactive resilience support to Staff and key workers, with psychological input.			System workforce, families / carers supported	Financial and WTE impact
5	Long Term Plan	Memory Assessment resource across Hull and East Yorkshire to maximise ability to manage demand and achievement of key performance requirements Perinatal Specialist Services expansion across Humber to meet NHS LTP Objectives.	Continued contribution to ICS MH Work stream	Continued contribution to ICS MH Work stream	Dementia diagnosis rate to achieve 66.7%	Financial and WTE impact

Section 4e:

Acute Sector

Acute Sector Summary

Challenges and Opportunities	Key Deliverables /Priorities
• Acute services will not return capacity to close to previous levels any time in 20/21 within the current resources. This is due to the ongoing impact of a reduced workforce; the staffing demands of the Covid areas and the impact of enhanced PPE and cleaning on elective productivity. • The current PPE and IP&C requirements will continue for phase 3 meaning the productivity of elective procedures will be impacted (20-40% depending on volume of cases per list • For Covid admissions we will retain capacity, including in critical care, to accommodate May 2020 levels of activity and have a surge plan that can accommodate 150% of the first peak	• Clinical triage of referrals and deployment of advice and guidance, streaming straight to test etc • Embedding remote consultation by both telephone and video • Clinical validation of patients awaiting follow up and moving patients to patient-initiated follow-up pathways or discharge with results • Radiology review of diagnostic requests; redirection to lower invasive tests where appropriate • Clinical prioritisation processes that target resource at highest priority cases • Use of independent sector capacity
Resource Requirement	**Risks**
• HUTH plans also include 19,000 additional diagnostic procedures • Revenue cost of additional activity during phase 3 (Aug – 2020-March 2021) is £21.8m • Capital costs of £13m associated with phase 3 recovery plan, • NLAG plans also include x additional diagnostic procedures • Revenue cost of additional activity during phase 3 (Aug – 2020-March 2021) is £xm • Capital costs of £xm associated with phase 3 recovery plan	• Both the total list size and the number of over 52 week waiters are forecast to massively increase over the phase 3 period. Patients on these lists will need to be reviewed and managed to reduce risk of harm • Securing additional clinical staffing will be challenging • Diagnostic services are facing unprecedented pressures. Measures being implemented to address these issues include clinical prioritisation, triage and diversion to alternative tests and utilisation of independent sector capacity

Acute sector planning assumptions

Demand Assumptions

The below are the assumptions to the levels of demand for Trust's plans. For example, for Q2 within referrals, the Trusts have modelled 70% of their previously expected referral rates.

		Q1		Q2			Q3			Q4		
Referrals (all)	N/A	70%	70%	70%	70%	70%	80%	80%	80%	80%	80%	80%
Referrals (2WW)	N/A	70%	70%	90%	90%	90%	90%	100%	100%	100%	100%	100%
Non-Elective Demand	N/A	70%	70%	80%	80%	80%	90%	90%	90%	100%	100%	100%

NB: 2WW demand is a subset of all referrals
NB: Due to demand at NLAG already increasing at more than that assumed, the demand assumptions for the Trust for non-electives increases to 100% from August 2020

Capacity Assumptions

- For **Covid admissions** we will retain capacity, including in critical care, to accommodate May 2020 levels of activity and have a surge plan that can accommodate **150%** of the first peak (but will deploy this as needed rather than have the facilities sitting staffed and idle)
- Covid impact on available workforce (staff shielding, self isolating or sick with Covid) **- c5%**
- Impact of 2m bedhead spacing **-10%** of bed stock
- The current PPE and IP&C requirements will continue for phase 3 meaning the productivity of elective procedures will be impacted (20-40% depending on volume of cases per list
- Sufficient PPE will be available
- Access to independent sector capacity will continue.

Acute sector planning approach

- The Trusts have in response to Covid-19 and the level of activity experienced in the 1st peak, set out the arrangements for safe care of an ongoing level of Covid -19 patients during Phase 3. This includes continued provision of Covid-19 assessment, general acute and critical care.
- The Trusts have modelled the expected overall non-elective demand for phase 3, as set out on the previous slide. This has in turn informed revised bed numbers and configurations for non-elective services and capacity plans for acute diagnostics and theatres.
- The Trusts have been closely monitoring Covid-19 related staff absence and it is running at c5%. For ward and theatre based staff this has been built into the workforce plan.
- Taking the above factors into account, we have developed workforce plans to staff these services.
- We have then worked through what capacity we can staff in outpatients, diagnostics and theatres and adjusting it for the reduced productivity we are experiencing as a result of the enhanced PPE and cleaning regimes, developed an elective activity plan.
- The outpatient plan also takes account of the new ways of working; the details of this are articulated in the next slide

Elective activity plans – Base Case

Provider	2019/20	2020/21	Variance (%)	Variance (#)
HUTH - Revised	867,770	553,270	-36.2%	-314,500
Elective IP	15,162	7,415	-51.1%	-7,747
Daycase IP	72,923	36,784	-49.6%	-36,139
New OP	245,505	138,146	-43.7%	-107,359
Follow-up OP	534,180	370,924	-30.6%	-163,256

Provider	2019/20	2020/21	Variance %	Variance
NLAG - Revised	**432,819**	**334,768**	**-23%**	**- 98,051**
Elective - Full	6,541	1,973	-70%	- 4,568
Elective - DC	52,720	26,919	-49%	- 25,801
New OP	119,926	77,418	-35%	- 42,508
Follow-Up OP	253,632	228,458	-10%	- 25,174

- Acute services will not return capacity to close to previous levels any time in 20/21 within the current resources. This is due to the ongoing impact of a reduced workforce; the staffing demands of the Covid areas and the impact of enhanced PPE and cleaning on elective productivity.
- Should we see a change in the guidance in relation to PPE and cleaning this would improve productivity.

Optimising delivery within constrained resources

The acute providers have in response to the challenge of Covid -19 implemented a wide range of initiatives designed to optimise the deployment of their resources.

Key measures include:

- Clinical triage of referrals and deployment of advice and guidance, streaming straight to test etc
- Embedding remote consultation by both telephone and video
- Clinical validation of patients awaiting follow up and moving patients to patient-initiated follow-up pathways or discharge with results
- Radiology review of diagnostic requests; redirection to lower invasive tests where appropriate
- Clinical prioritisation processes that target resource at highest priority cases
- Use of independent sector capacity

In addition to the work within Trusts, we are working with partners across the ICS, within the cancer and elective hub arrangements to ensure parity of prioritisation across the patch and to develop refined clinical pathways

Some face to face outpatient capacity has been built in to account for those patients who require direct contact and to reach those groups where digital poverty is an issue or where people are unwilling to engage in a digital solution.

RTT and 52 weeks

NLAG

Activity Line	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total numbers of patients on an incomplete pathway at month end	22,865	24,554	24,940	25,886	28,023	30,349	31,616	34,122	36,369
RTT 52 week waits	192	281	429	741	1,221	1,921	2,902	3,910	4,992

HUTH	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total numbers of patients on an incomplete pathway at month end	55,980	55,901	56,440	59,813	62,398	62,298	66,982	71,396	72,101
RTT 52 week waits	3,181	4,920	6,979	9,412	13,275	15,968	21,928	28,668	34,566

% prioity disposition of Humber incomplete PTL; snapshot as at 14/07/20

Priority	Percentage
P1a	0.14%
P1b	0.19%
P2	9.74%
P3	23.66%
P4	66.3%

To note: Higher priority categories have much faster churn so % snapshot cannot be used to estimate % in each category treated within a month or year.

Clinical risk management of RTT and 52 weeks

Management of risk within the PTL

- Both the total list size and the number of over 52 week waiters are forecast to massively increase over the phase 3 period
- In recognition of this, both trusts have implemented a rigorous approach to management of clinical risk within the PTL and undertake the following steps
    1. All referrals are clinically reviewed on receipt
    2. Any patient not appointed by 12 weeks is clinically reviewed and every 12 weeks thereafter (HUTH). Urgent patients should be appointed within 6 weeks, and are flagged until they are, routine patient will be triggered a further review as they trigger 18w (NLAG)
    3. The admitted PTL has been reviewed and prioritised in line with RCOS guidelines, new additions have their priority assessed
    4. Specialties review and present their priorities for access to theatre lists to a clinically led theatre resource allocation panel. Any inability to appoint priority 1A, 1B, 2 or 3 that is over 12 weeks is escalated for resolution
    5. Patients who are at risk of reaching 52 weeks have a further clinical review . If patients have not been risk stratified previously, a clinical harm review will be undertaken as the patient triggers 52ww.

The Trusts are working with primary care colleagues to review referral thresholds and to ensure patients are counselled on the risks and benefits of potential treatment and are prepared to isolate prior to elective admission

Managing diagnostic pressures and screening services

Across the Trusts our diagnostic services are facing unprecedented pressures. Both Trusts were already, pre-Covid 19, operating their key diagnostic services 7 days per week and in the case of MRI and CT, over extended hours.

Endoscopy was unable to undertake either suspected cancer or routine diagnostics for a number of weeks during the first Covid peak and as a result has a significant backlog to address.

Due to the high volume of cases that go through each session for these diagnostics, productivity is disproportionately affected by the PPE and enhanced cleaning requirements currently in force, with sessions accommodating 50-60% of usual cases.

Measures being implemented to address these issues include:

- Clinical prioritisation of referral by specialty teams
- Triage by Radiology of imaging referrals and diversion to alternative tests where appropriate
- Utilisation of independent sector capacity and whilst available, screening capacity for diagnostics

In addition we are working with the ICS and Regional Diagnostic Leads to bid for additional equipment and extension of Rapid Diagnostic Centres in the Humber

Acute Sector delivered screening services

Plans have been developed to restart the Breast, Bowel, and Lung Screening services; however capacity is expected to be at 50 – 60%

Cancer waiting times management

The Trusts are working internally and together, via the Humber Cancer Board, to safeguard cancer pathways and recover cancer performance, in the context of the ongoing constraints in diagnostic capacity.

Referrals were down in April and May 2020 but are now returning to pre-Covid levels and plans are being developed to address a surge in referrals, as the lock down is progressively eased.

Specific measures being taken to support cancer delivery include:

- Retain clinical triage of 2ww referrals signposting clinically appropriate patients to Straight to Test (risk stratification of patients with high risk of cancer, e.g. use of FIT in Colorectal)
- Increase use of advice and guidance to GPs, particularly in tumour sites where cancer conversion rates are below 5%
- Increased diagnostics and/or treatment in green zone(s)/independent sector/ facilities where appropriate
- Development of tumour site recovery plans
- Clinical risk assessment of patients on cancer pathways (safety netting), particularly for patients reluctant to attend diagnostic test procedures/treatment.
- Re-focus on timed pathways designed to support recovery building on new ways of working
- MDT equipment upgrade to facilitate virtual MDT functionality
- Acceleration of development and implementation of self-supported follow up pathways
- Development of Rapid Diagnostic Centre pathway for Upper/Lower GI

Workforce Issues

- Absence and sickness rates have increased across the Trust as a result of shielding and self-isolation but also in general which could be symptomatic of staff becoming run down. These numbers are reducing Covid 19 incidence reduces and we are working to get shielded staff back to work from August into Covid secure environments.
- Levels of untaken annual leave are higher than usual as a result of C-19. Staff will need to begin taking this annual leave to enable this to fit within the financial year where possible and also to get some rest.
- Vacancy levels have remained stable within the first quarter of 2020 with many staffing pipelines slowing during the pandemic. It is expected that these pipelines will begin to increase from August onwards as lockdown measures continue to ease and as international borders begin to open.
- If C-19 protective measures are reduced in clinical areas, additional workforces would enable greater levels of activity seeing full utilisation of clinical space and allowing for additional sessions to take place without increasing the stress levels of existing workforces.
- Where additional clinical space and equipment can be made available on-site, additional clinical staffing will be problematic to enable activity. This will be the case if the Trust source staff directly or through an agency. For example, if the Trust are able to source a mobile CT Scanner, the Trust will need to also source 6.5 WTE radiographers to run the asset at full capacity – Radiographers remain a hard to fill role nationally and are also in demand across the country.

Elective activity plans – additional resources and use of the independent sector

Provider	2019/20	2020/21	Variance (%)	Variance (#)
HUTH - Revised	867,770	553,702	-36.2%	-314,068
Elective IP	15,162	8,776	-42.1%	-6,386
Daycase IP	72,923	41,608	-42.9%	-31,315
New OP	245,505	152,123	-38.0%	-93,382
Follow-up OP	534,180	351,195	-34.3%	-182,985

- HUTH plans also include 19,000 additional diagnostic procedures
- Revenue cost of additional activity during phase 3 (Aug – 2020-March 2021) is £21.8m
- Capital costs of £13m are associated with the phase 3 recovery plan, see later slide for more detail

NLAG - This slide relates to stepped up case, currently being developed and modelled into base case, not due for submission today

- NLAG plans also include x additional diagnostic procedures
- Revenue cost of additional activity during phase 3 (Aug – 2020-March 2021) is £xm
- Capital costs of £xm are associated with the phase 3 recovery plan, see later slide for more detail

Use of the IS

- Both Trusts are working closely to utilise the operating and diagnostic capacity within their local IS providers that are part of the national NHS contract: St Hugh's in NE Lincs and Spire in E Riding. The theatre and diagnostic capacity has been fully integrated into the Trusts' prioritisation and booking processes
- The limiting factor is workforce: anaesthetists, surgeons radiographers
- We do not anticipate needing to utilise all of the outpatient or bedded capacity
- There is also as yet no confirmation of the capacity being available beyond August 2020.

Activity forecast: if the capacity were to be available for the whole of the phase 3 period; we anticipate this would allow an additional x EIP and daycases and x diagnostics to be undertaken

Humber Acute Services

A 5 site / 2 Trust / 4 CCG System

- The Humber Acute Services Review (HASR) is developing proposals for consideration in Q4 20/21- Q1 21/22 for the long term provision of acute services, reflecting ambitions for **modern service integration, reshaping education and training provision** and **significant capital investment** for our patients, communities and our staff.
- An interim clinical plan will integrate acute services – service change proposals may follow where required to address workforce challenges and quality standards:

(0-3 months)	(4-6 months)
•Haematology •Neurology •ENT •Dermatology •Scoping Cancer pathways	•Cardiology •Gastroenterology •Urology •Ophthalmology

Shift from single-Trust to integrated acute service provision in 2020/21 and 21/22. Engagement with patients, public and staff will be undertaken to develop a range of clinical proposals.

- Service change proposals developed as part of the interim clinical plan will draw upon (1) Yorkshire and Humber Clinical Senate Recommendations (2) Shift in-year to Advice and Guidance and Digital First (3) Reorganising access to routine services to maintain effective infection, prevention and control.
- Service proposals in the interim and long term will significantly ramp up the level of integration day to day between (a) hospital specialists working from different geographical bases and (b) hospital specialists and GP, optometry and social care services.

Source: Senate report: http://www.yhsenate.nhs.uk/index.php

Section 5:

Resource and Investment

Digital Technology

Summary
Throughout Phase 3, we will build on successes in the immediate COVID response period to accelerate rollouts of technology enabled care across all sectors, to reduce face to face attendances and maximise productivity, by investing in projects to improve access, support prevention and long term condition management and address digital inclusion

Access	Digital Inclusion (Stepped Up Case Only)
• Continued rollout of telephone and video consultations across primary and secondary care, including video consultation into care homes • Continued and further deployment of devices and infrastructure to enable remote working and digital consultation • Accelerate progress towards shared patient records • Use of digital platforms for mental health assessment and treatment • Continue to roll out digital support and consultations for people with LD and Autism following positive feedback	• Development of VCS-led (Digital) Health Hubs across the Humber, linked to PCNs, to reduce digital exclusion / health inequalities • Provision of connected tablets for those patients without Internet to allow access to online services • Further enhancing a Primary Care portal to used to capture the digital maturity of patients in order to ensure the right inclusion model. • Provision of Digital Hubs within Practices to allow patients to access online systems and digital tools from within practices

Risks
• Risks exacerbation of health inequalities for people with are unable to access digital provision – some people may need to be supported to access digital services and it will be important to retain non-digital access routes for some patients. Schemes to address digital inclusion are subject to approval of additional funding. • Undertake evaluation of digital initiatives and identify where these may exclude some service users (digital poverty) and put processes in place to mitigate against this exclusion/support contact intervention preference of face to face as an alternative. Solutions for reducing digital poverty for those residing in supported living

Workforce Summary

Challenges and Opportunities	Key Deliverables / Priorities
• C-19 impact on capacity and demand has exacerbated existing workforce pressures in particular areas e.g. mental health services, social care, care homes, primary care, fragile acute services • Workforce is at significant risk of health and wellbeing issues resulting from C-19 experiences from anxiety / depression to 'post-trauma', burn-out, etc. and impact on families / carers • rHNA highlights those from BAME / LGBTQ and other protected / vulnerable characteristics will require greater support. Our workforce has significant representation from these groups with some organisations having a disproportionate number compared with the general population • 'Anchor' institutions to work with communities to stimulate local job markets to support economic recovery • Impact on VCSE organisations and volunteer retention • Workforce need the capacity, capability and confidence to utilise new technologies and remote working models • Flexible working models to be adopted / sustained	• Consistent Health and wellbeing offer across the system • Black lives matter-BAME development into leadership roles • Develop Inclusivity for all minority groups • Development of best practice people policies including flexible working / movement between organisations • Talent management / Leadership / Organisational Development across system • Through the Workforce Consortium, complete workforce modelling alongside HEE to develop 5 year plans • Develop a HCV People Plan with clear Humber outcomes and deliverables • Develop Union partnerships across HCV
Resource Requirement	**Risks**
• Time for senior leaders away from operational management • Recurrent funding to match demand / capacity workforce modelling outcomes	• Workforce availability to support latent demand / backlogs / Second Surge leading to worsening health outcomes • Timescales / recurrent funding to address workforce availability • Insufficient attention to particular groups, resulting in worsening health inequalities

Workforce Delivery Plan Summary

No	Key Deliverables /Priorities	Q2	Q3	Q4
1	Consistent Health and Wellbeing offer across the system	Tailored support offer to those in greatest Emphasis on wellbeing and health including taking leave, acknowledging caring responsibilities, impact on families, etc.	Introduction of specialist services Continued delivery of support	Staff health and wellbeing is improved across Health and Care leading to higher levels of recruitment, retention, job satisfaction and/or productivity
2	Development of best practice people policies including flexible working / movement between organisations	Alignment of policies to enable movement of staff and volunteers around the system Embed flexible / remote working, ensuring workforce is supported from a health and wellbeing and logistical perspective	Multi-provider projects are established that promote integrated 'whole system' approaches to workforce solutions	A system-wide process for levy transfer is implemented that supports smaller employers with apprenticeship activity
3	Develop workforce modelling alongside HEE to develop 5 year plans	Capacity and Demand analysis – risk stratified / phased approach aligned to sector level operational plans	Inform People Plan development Allows active recruitment / retention	Allows active recruitment / retention
4	Proactive support to BAME / LGTBQ and vulnerable groups within our workforce	Targeted programme of support agreed across the Humber / delivery commenced. Diverse mediations support for BAME colleagues through the NHS People website	Develop and share further insights from initial supporting mechanisms Diverse mediations support for BAME colleagues through the NHS People website	Refinement of offer Diverse mediations support for BAME colleagues through the NHS People website
5	People Plan including recruitment, retention and return to work	Ensure General Practices across HCV are digitally ready to maximise learning opportunities Career Pathways, based on the Excellence Centre model, are developed for each local area	Local community/system wide targeted approaches to working with schools and colleges, promoting Health and Social Care careers is planned/established Increase learning opportunities for hard to reach groups and care staff though the hospice led initiative - ECHO	Placement capacity and communication across Health, Care and Education is increased leading to a greater number of placements being available within each community/locality The number of Nursing Associates in Social and Primary Care is increased

Phase 3 Finance

Revenue

- Tracking of the actual expenditure levels for COVID and BAU across providers and commissioners across the geographical footprint
- Acknowledge financial regime for month 1 – 4 will be extended to month 5 and likely month 6
- Gearing up to respond to the revised guidance for the second half of 20/21 and beyond when it is received
- Inaugural meeting of the Humber Oversight Management Board which will oversee all aspects of finance and non finance delivery
- Some very high level view on the impact of “step up” case but much more work required particularly in terms of confidence in delivery from a workforce availability perspective

Capital

- Provider level bids have been received into the ICS for in and out of hospital services
- There is still no confirmed capital allocation for the ICS or geographical footprint
- A very high level of prioritisation has been undertaken
- Largely driven by potential specific funding allocations for e.g. ED and diagnostics quickly followed by COVID security with expansion of bed base being a lower priority
- Mary Seacole proposals included: 1 North Bank 1 South Bank however much more work required particularly on how they meet the discharge ask
- Mary Seacole categorised as a medium priority purely to log our intent to establish something but not necessarily as described in the bids

Humber Phase 3 Capital Proposals

Sum of TOTAL 20/21 £	Column Labels												
Row Labels	A & E	Digital A&E	Adult critical Care Beds	Other NICU so not adult	Diagnostic	Digital	General and Acute Beds	Theatre Capacity	Rehabilitation Beds	Mental Health	Out of Hospital	Premises Covid Secure	Other	Grand Total
HCV ICS Digital		2,366,000				9,948,000								12,314,000
Hull University Teaching Hospitals NHS Trust	4,500,000		1,421,749	329,546	4,808,272		738,424	1,015,000	27,660			428,100	147,659	13,416,410
Humber Teaching NHS Foundation Trust							36,000			1,191,000		500,000		1,727,000
NHS East Riding of Yorkshire CCG									4,800,000					4,800,000
NHS North East Lincolnshire CCG						23,500			318,682	250,000	35,931	318,000	30,000	976,113
Northern Lincolnshire and Goole NHS Foundat	6,174,000		627,904		863,667	88,836	8,400,000	1,998,363				4,019,821	1,255,199	23,427,790
Grand Total	**10,674,000**	**2,366,000**	**2,049,653**	**329,546**	**5,671,939**	**10,060,336**	**9,174,424**	**3,013,363**	**5,146,342**	**1,441,000**	**35,931**	**5,265,921**	**1,432,858**	**56,661,313**
Pre-committed			- 1,844,653	- 329,546	- 156,922		- 38,424						- 8,659	- 2,378,204
Revised Total	**10,674,000**	**2,366,000**	**205,000**	**-**	**5,515,017**	**10,060,336**	**9,136,000**	**3,013,363**	**5,146,342**	**1,441,000**	**35,931**	**5,265,921**	**1,424,199**	**54,283,109**
Of which														
High Priority	9,752,000	2,366,000	-	-	4,463,250	9,971,500	9,100,000	1,000,000	-	250,000	35,931	1,187,221	140,428	38,266,330
Medium Priority	-	-	-	-	-	-	-	-	5,118,682	-	-	3,403,600	-	8,522,282
Low Priority	922,000	-	205,000	-	1,051,767	88,836	36,000	2,013,363	27,660	1,191,000	-	675,100	1,283,771	7,494,497
Total	**10,674,000**	**2,366,000**	**205,000**	**-**	**5,515,017**	**10,060,336**	**9,136,000**	**3,013,363**	**5,146,342**	**1,441,000**	**35,931**	**5,265,921**	**1,424,199**	**54,283,109**

Section 6:

Humber System Governance

Humber System Governance

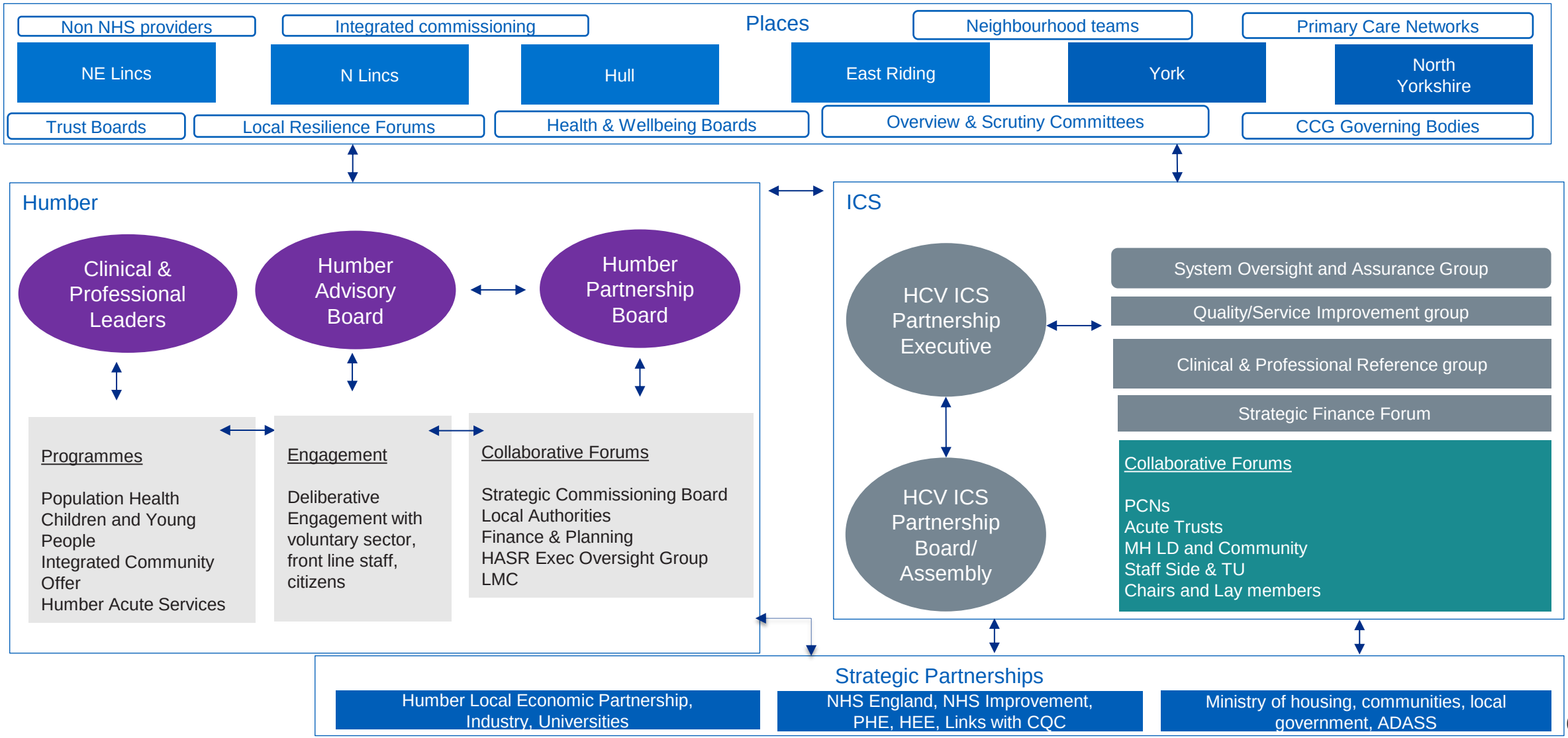
The newly formed Humber system is founded on the collaborative relationships that exist alongside our formal relationships to statutory bodies. This means we remain cognisant of our individual obligations but seek out opportunities to do things better, together.

Our Partnership will make decisions at the right time within appropriate levels of delegated authority with all partners being able to influence decision making, including our local people, elected representatives, lay members and our professional and clinical workforce. This section describes how this will happen in practice.

Our Intentions for the Way We Work

- Principle of *Inclusivity* supported by an MOU that sets out clear governance aligned to statutory bodies
- Humber Advisory Board guiding strategic direction to the Partnership Board – Chair / lay member / elected members.
- Clinical and Professional Leaders Board – Clinical Chairs, MDs, Nursing, AHPs, PCNs, DASS, DCS
- Flexible approach to people leading on areas of work for the system, regardless of employment status
- Single line of site for reporting into NHSE/I and ICS for the Humber population.
- Single route in for external strategic partnerships
- Single system plan with one finance lead and one planning lead

Collaborative relationships exist alongside our formal relationships to NHS and statutory bodies



Section 7:

Emergency preparedness, resilience and response (EPRR) and Winter / Surge Plan

Humber System EPRR Governance Arrangements

The Humber LRF and the Humber Partnerships coordination and incident management hubs are the main vehicles to ensure :

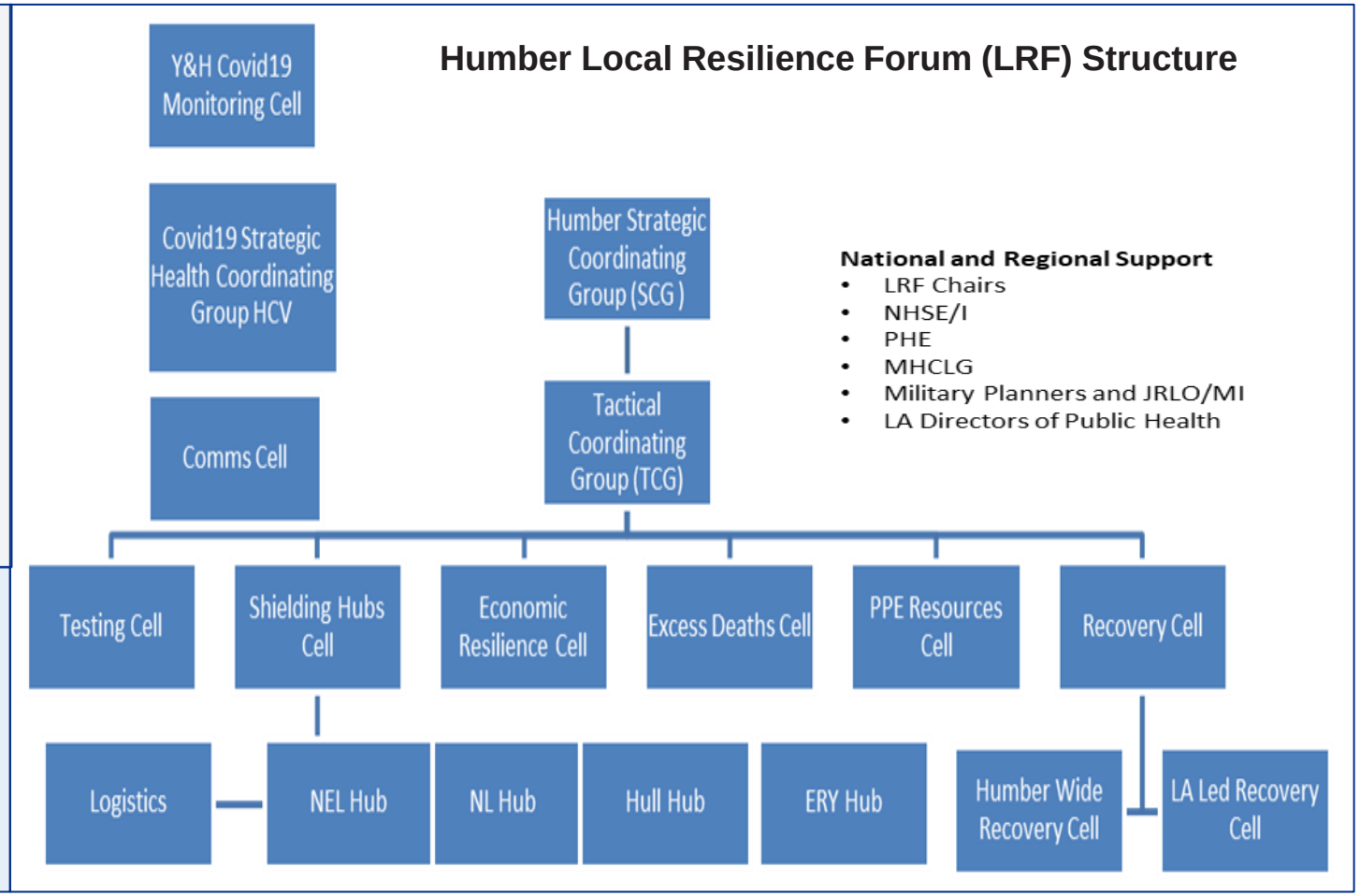
1. **Resilience** - Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges.
2. **Response** - Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by the emergency

Co-ordination Hubs/Incident Room Roles

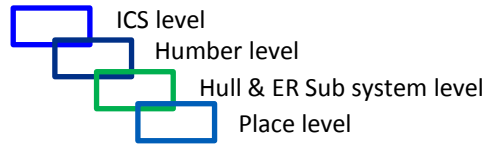
- Manage the Humber pandemic response
- Support primary care and care homes.
- Facilitate production of integrated local sector-wide health plans
- Contribute to multi-agency emergency planning at system level
- Implement response plans for Infection Control and Prevention, including PHE Communicate EPRR guidance and information out to local organisations
- Maintain a strategic overview of the impact on local organisations

Humber system EPRR Mechanisms

- Preparation & Planning (including training and scenario testing and exercising)
- Communication and Coordination
- Joint understanding of risk
- Shared situational awareness



Humber Incident Management Structure - COVID 19 V4



Communications Cell(s) supporting at all levels

HCV Covid-19 Strategic Health Co-ordination Group (SCG) (weekly)

HCV Covid19 Core Leadership (SCG) (weekly)

Hull East Riding Provider Alliance (HTFT, HUTH, Hull CC, ERYC, CHCP YAS) (SCG) (weekly)

LRF Strategic Coordination Group (SCG) (Daily/ 7days)

Humber CCGs Strategic Oversight Group (weekly)

Northern Lincolnshire Covid Strategic Coordination Group (NL Place partners) (SCG) (weekly)

LRF Tactical Coordination Group (TCG) (Silver Command) (Daily/ 7days)

Hull & ERY CCG Tactical Co-ordination/Response Group (TCG) (Weekly)

NLCCG Tactical Co-ordination/Response Group (TCG) (Mon/ Weds/ Fri)

NELCCG Tactical Co-ordination/Response Group (TCG)

(Hull & ERY CCG) COVID (TCG) Primary Care (weekly)

COVID19 System calls/ contact Hull & East Riding/ N Lincs/ York

NL Covid 19 Committee

NEL Union Covid 19 Committee

LRF Cells

Task & Finish Groups/ System Resilience Groups

Humber System Resilience

Principles
The Humber partnership will continue to **work within established local system governance to support the health and social care systems** in their role of providing continuous treatment and support to our populations with the added impact of Covid-19 or its complications whilst maintaining other essential care.
Agreements will be reached to **support resilience and response across health and social care**, including the ability to quickly repurpose and direct 'surge' capacity.
Local actions are agreed with providers and local authorities at place through system command and control structures and A&E delivery boards.

Scope of System Resilience	
Monitoring of Covid treatment capacity -utilisation of regional and local capacity data and assurance of provider arrangements for covid/non-covid separation	**Community Beds** –joint plans to manage step up and step down facilities including care homes, daily SITREP information, ability to flex capacity according to demand.
Seasonal planning –local system plans for winter 2020/21 potential second surge and seasonal flu preparation	**Local Outbreak Plans** –agreements in place to support plan implementation, impact on workforce of test and trace.
Communications –national and local information on flu vaccination and how to access urgent care	**Primary care** - Supporting PCNs at place, monitoring demand on primary care in line with daily sitreps and triggers for escalation
Humber CCGs oversight – providing assurance and agreeing mutual aid as required.	**Escalation** – Utilisation of current CCG EPRR arrangements to support escalation and manage de – escalation
Place – addressing how where local variations impact on capacity and surge planning	**MH/LD and services for children and people with autism** - attention to capacity at Humber and place within acute and community services working closely with the voluntary sector and ensuring support for carers

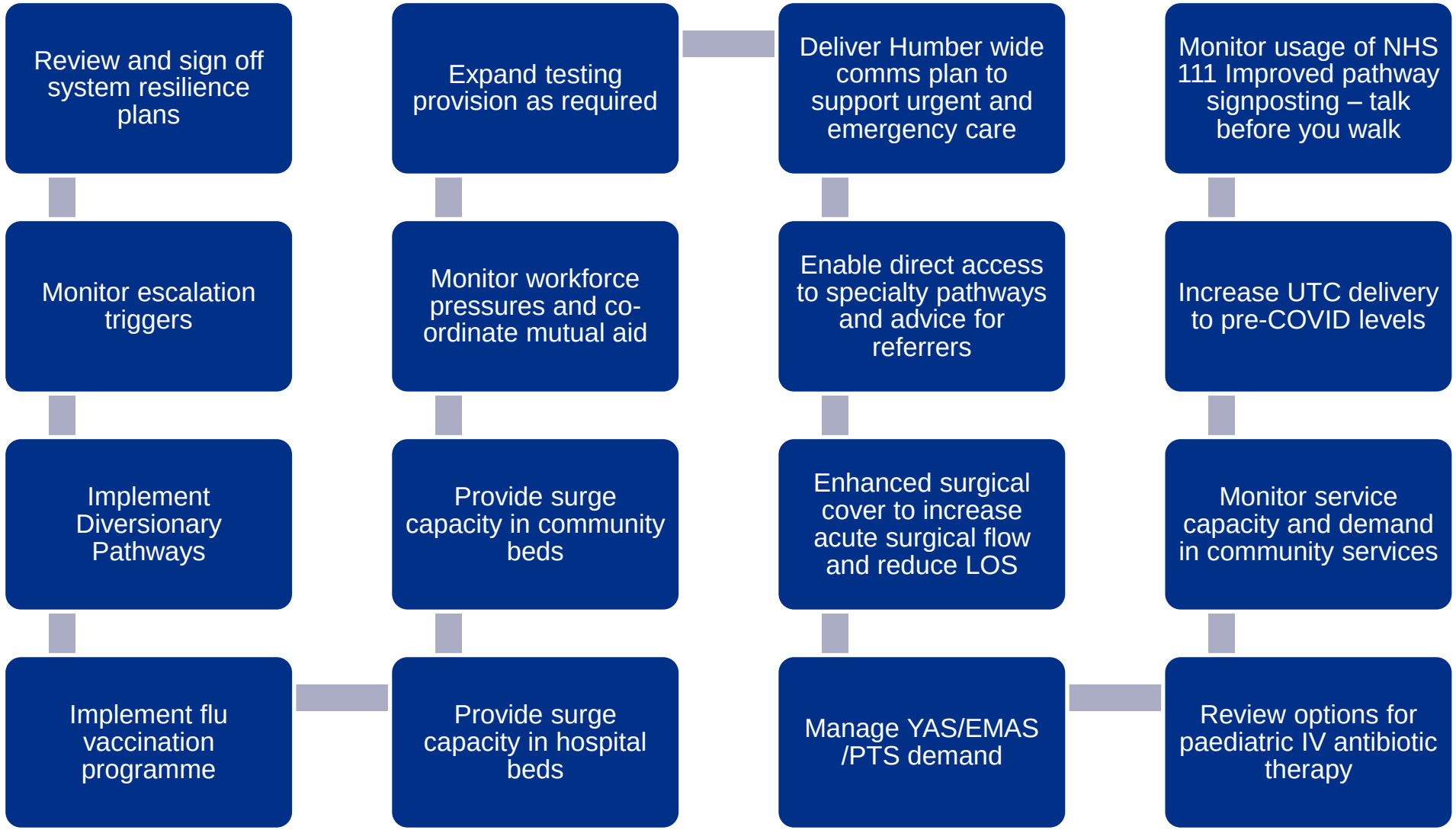
Winter/surge planning

To deliver effective winter and surge planning, the Humber system will work with:

- The ICS Urgent and Emergency care network, to deliver national guidance at sub system and place level.
- 2 A&E delivery boards (Hull & East Riding and North & North East Lincs) with responsibility for subsystem operational planning

A&E Delivery Board Responsibilities
• Deliver the 4hr A&E standard
• Develop plans for surge with agreed triggers of escalation in hospital and community services
• Provide local reporting and on call arrangements to monitor delivery in and out of hours
• Plan for and provide capacity to meet peaks in demand and seasonal pressures
• Manage system risks that impact on emergency and urgent care
• Reduce Delayed Transfer of care (DTOC)
• Improve step up, discharge/transfer and patient flow through the hospital and community beds
• Ensure smooth and timely ambulance handover to support ambulance response times
• Streamline A&E front door processes e.g. primary care streaming & mental health response
• Communicate public information about access to and use of urgent and emergency care pathways
• Ensure the adoption of best practice in respect to urgent and emergency care
• Seek assurance on and work with PHE on Flu and pneumonococcal Immunisation Programmes
• Increase uptake and improve access to community urgent care and diversionary pathways

Winter / Surge Planning Key Actions



Full plan included at Appendix 2

Appendix 1:

EQIA

Definitions & Plan

The Equality Act 2010 protects against discrimination, harassment and victimisation

The Humber partnership is committed to eliminating discrimination and promoting equality in the design and implementation of services, policies and measures that meet the diverse needs of their populations and workforce, ensuring that no individual or group is disadvantaged.

All contracts determine and seek assurance that

- Equality is based on the principle of providing equality access to services, in the context of the Equality Act 2010.
- Diversity, in this context means recognising and valuing difference in individuals and communities.
- Equality impact assessment is a process of explicitly considering the likely equality impact of new or changes to existing policy, project or functions
- The CCG and providers approach to EQIA supports adherence with the NHS Constitution

The Humber Partnership undertake an equality impact assessments for all of the following:

- New or reviewed policies
- Strategies
- Services Specifications
- Business Cases
- Service reviews
- Any decommissioning activity; and any other project that will have a significant impact on staff, patients or the public

In 2020/21 the Humber CCGs will continue to ensure that there is provision within all contracts to ensure that providers comply with the Equality Act 2010 and specifically that they will undertake activities to ensure that they comply with the Public Sector Equality Duty, regardless of their individual legal status

EQIA - Action Plan 2020/21 – emergency response phase

Identified Risk	Actions 2020/21	Lead	Completion/Review date
Possible Impact over the duration of legislative and regulatory requirements of the Covid-19 pandemic and emergency situation	Where provisions have to be made in this context safeguards and mitigation measures are in place within and across the Humber commissioning and provider partnership to lessen the extent of any negative actual or perceived impacts on protected groups The likely impact of new policies and practices, on Race, Gender and Disability equality; to be carried out through Equality Impact Assessments (EQIAs)	To be agreed	December 2020
Prioritisation due to COVID legislation of who and what type of needs are met, rather than required to meet all eligible assessed needs as specified under the Care Act 2014	That these are temporary and regularly reviewed with governance in place to seek professional and clinical review of restart and reset of services and that EQIA assessments are reviewed and undertaken as services recommence	To be agreed	September 2020
Enhancing capacity and the flexible deployment of staff	Safeguards to ensure oversight and accountability within each employing organisation Humber MOU to support mutual aid complainant with Equality Act	To be agreed	September 2020
Containing and slowing the virus	The Humber partnership will work at place with Public Health leads in implementation of local outbreaks plans and apply guidance in line with national and regional directives and ensure attention to the needs/ greater risks to people from protected groups and make sure information is produced in compatible formats	To be agreed	August 2020

EQIA - Action Plan 2020/21 – Recovery

Identified Risk	Recommended Actions	Lead	Completion/ review date
Lack of engagement with patients and public on the positive and negative impact of service changes during the emergency response phase could result in adverse equality impact	Updated equality objectives integrated across Humber Partnership Agree work plan to take 'What we're learning' approach locally, across Humber, and through the Y&H E&D Leads Network	To be agreed	September 2020
Poor uptake of preventative services and late presentation of already disadvantaged groups to primary/secondary and community care due to lack of understanding about changes to service delivery	Programme of sessions / dialogue including decision makers, operational leads and community local interest input, framed by these questions: What do we know? What's working well? What needs strengthening? What can we do about it? Who else needs to be included in discussions?	To be agreed	December 2020
Patient & public confidence in accessing services is not understood when embedding and prioritising post Covid19 changes .			
Impact on BAME workforce across primary care affects capacity and delivery of care	Identify Equality and inclusion champions / advocates in Primary Care to design and deliver system wide approach	To be agreed	August 2020

Outcomes

- Improved access to information and minimise communications barriers
- Equality is consciously considered in all commissioning activities and ownership of this is part of everyone’s day-to-day job
- Recruit and maintain a well-supported, skilled workforce, which is representative of the population we serve
- We are welcoming and inclusive to people from all backgrounds and with a range of access needs
- To demonstrate leadership on equality and inclusion and be an active champion of equalities in partnership programmes or arrangements
- Meaningful outcomes from EQIA integrated into 2021-22 Plan

Appendix 2:

Winter / Surge Plan

Priority	Q2	Q3	Q4
System resilience plans	Review of plans for 19/20 completed and key themes / initiatives identified and incorporated into 2020/21 plans Ensure they remain fit for purpose in light of COVID19 delivery to be overseen by the respective A&E delivery Boards Cross reference between Hull & ERY and N&NE Lincs plans for joint opportunities	System Plans signed off by A&E delivery boards Demand and capacity planning and scenario test conducted before the end of October 2020	Plans operational monitored by monthly A&E delivery Boards
Escalation triggers	Each system partner to review escalation triggers incorporating COVID19 information linked to local outbreak plans and monitoring of infection rates	Deliver timely and effective system response in line with OPEL framework. Ensure in place across all partners feeding into a daily system report to deliver coordinated response as required Review of operational effectiveness and any implement any modification prior to Jan 2021	Monitor and review weekly on system calls linking into EPRR process if required
Diversionary Pathways	Review of effectiveness of diversionary pathways away from ED into alternative hospital and community based services Review of step up / outreach opportunities	High intensity user programme – expansion of service to include whole Hull and ER population Implementation of 75HIU programme potentially through social prescribing models and linked to frequent attender programme. Psychiatric liaison and Haven crisis response pilot extension. Development and implementation of falls service. Further evolution of SPA response (N & NE Lincs)	Implement and review
Vaccination	Updated guidance on vaccination programme expected September 2020 Gather data on local constraints to delivery of immunisation programme in light of COVID 19. Use previous years data and anticipated impact of capacity to deliver and expected uptake. Identify any stock or distribution issues and prepare risk register Focus on staff, especially patient focus, to promote uptake as well as patient uptake	Vaccination programme underway Plan for Flu and Pneumonia in place and being delivered	Monitor delivery and uptake working with PH and Primary care to understand risks to delivery and potential impact.

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Vaccination	Updated guidance on vaccination programme expected September 2020 Gather data on local constraints to delivery of immunisation programme in light of COVID 19. Use previous years data and anticipated impact of capacity to deliver and expected uptake. Identify any stock or distribution issues and prepare risk register Focus on staff, especially patient focus, to promote uptake as well as patient uptake	Vaccination programme underway Plan for Flu and Pneumonia in place and being delivered	Monitor delivery and uptake working with PH and Primary care to understand risks to delivery and potential impact.
Hospital Beds	Increased demand for Covid19 aftercare and support in community health services, primary care, and mental health HUTHT increased COVID 19 'hot' beds	Ambition for SAFER Patient Flow operational on all wards	Four months of additional surge capacity – (HUTH winter ward 580K)
Community Beds	Undertake capacity and demand review of existing beds (Humber) Move towards flexible bed capacity and away from specified bed capacity with associated workforce flexibilities, building upon COVID 19 models, to enable bed usage to be more flexible in response to patient need Discharge to assess models reviewed for sustainability. Complete Intermediate Tier review including community beds and DTA process evolution (N& NE Lincs)	Establish dashboard to monitor capacity and agree plans quickly repurpose and step up 'surge' capacity Ongoing monitoring of bed usage and demand hotspots to support rapid flexing of available capacity to match demand Consolidation of discharge to assess approach Implementation of agreed intermediate tier review	Implementation and review Implementation of agreed intermediate tier review
Workforce	Each partner organisation to share workforce plans and impact on urgent care services Capitalise on flexibilities introduced in response to COVID	Agree risks and mitigation , mutual aid and in reach/outreach in escalation	Monitor and review

Priority	Q2	Q3	Q4
Testing	Review Microbiology & Virology capacity	Determine need to expand express testing and sustain additional testing capacity for winter pressure period, agree business continuity in event of capacity gap.	Monitor and review
Patient & Public Communications	Agree Humber wide Communications plan to support urgent and emergency care. Delivery to be coordinated in line with national messages and local service configuration	Deliver communications plan at agreed intervals using local media Key messages – COVID 19 prevention, Vaccination uptake, Talk Before You Walk, Chose Well, Safe Access (COVID 19)	Monitor impact of public communications against activity and demand across services and adjust accordingly Monitor healthcare seeking behaviour across services
Direct access to specialty pathways	Scope project plan for Acute services hub (HUTH)	Provide contact and referral service to GPs and other referrers for accessing acute specialty pathways in HUTH	Review impact uptake and impact
Surgical Pathways	Trust undertaking capacity and demand in line with elective restoration plans	Increase opening duration of H30 to 7/7 (HUTH – subject to investment)	Enhanced surgical cover to increase acute surgical flow and reduce LOS, deliver increased SACU and SAU pathway management (HUTH – Subject to investment)
YAS/EMAS /PTS	Review constraints on PTS due to social distancing requirements Assess opportunities to utilise voluntary and third sector transport Review response times for discharges EMAS plans across the full year Access to clinical advice, Access to alt pathways, Adv care in care homes Clinical staff behaviour changes/risk management Public attitudes and behaviour	Clarify capacity demand gap in relation to anticipated discharge timelines Confirm transport support for care home to care home / home journey's Review essential capacity for dialysis / chemotherapy	Monito service provision, pressures areas/opportunities Encourage patients to 'talk before they walk' and to consider family transport where possible

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Community Services – CHCP, Humber , RDASH, CarePLUS	Review current capacity and predicted demand/capacity for winter period Identify proactive/diversionary pathways to other clinically appropriate patients Continue to utilise none face to face appointments where clinically appropriate Support patients to take self ownership and self care measures Further pilot of HAVEN MH service to support attendance avoidance	Agree potential solutions for any predicted demand / capacity gaps Review bank staff availability and models Consider models of group support for appropriate patient groups / online support	Monitor service capacity and demand Adjust models where required Monitor clinical risk
NHS 111	Review NHS 111 usage and develop trajectories to increase usage in conjunction with NHS 111 Promote the use of NHS 111 online as an alternative to telephone Develop prior notification systems to inform ED of impending arrivals Review DoS to ensure up to date with regard to alternative pathways	Finalise and commence delivering communication plans around use of NHS 111 Explore opportunities for local CAS to support NHS 111 in times of crisis Continuous overview of DoS	Monitor usage of NHS 111 and their ability to meet performance targets Promote key messages as outlined above

Priority	Q2	Q3	Q4
Improved pathway signposting – talk before you walk	Review diversionary pathway opportunities as identified above Develop communication plans regarding how to get advice / contact service s prior to attending Develop plans for clear patient and clinical contact points for services where appropriate – with timely response Keep abreast of plans around NHS 111 as above	Launch communication plans Monitor opportunities for / develop local CAS for patient clinical triage and signposting Increased use of electronic signposting Test and review diversionary pathways, develop further opportunities	Monitor provision of local CAS and response times across both physical and mental health Tailor communications in response to live experience Consistent message and actions supported across the system
Urgent Treatment Centres	Increase UTC delivery to pre-COVID levels Review outcomes of NHSE/I assessment of UTCs Develop delivery Plan for any actions required		