Paper ref:	TB (10/20) 009

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	COVID-19 Overview		
Sponsoring Executive	David Carruthers – Medical Director		
Report Author	David Carruthers – Medical Director		
Meeting	Public Trust Board	**Date**	1st October 2020

1. Suggested discussion points *[two or three issues you consider the Committee should focus on]*

An increase in COVID cases in the community and how that is impacting on hospital admissions are discussed, as are implications on new IPC guidance on the Trust. With the increase COVID-19 admissions to the Trust there is a strong focus on reviewing and updating the previous treatment pathways and to make sure that these are rigorously followed, adopting evidence from research in the first wave. Focus of care of these patients on the respiratory Hub at City should allow this. Learning from mortality reviews from the first surge will be important in how we work to monitor community cases not requiring admission. Individual case risk assessment will be important.

The Phase 3 letter has a focus on restoration and recovery and the areas focused on in this phase are summarised.

TB is invited to discuss issues around COVID within these broad categories.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan		Public Health Plan	x	People Plan & Education Plan	
Quality Plan		Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Q+S 25/09/20

4. Recommendation(s)

The Trust Board is asked to:

a.	Consider new IPC guidance
b.	Discuss changes in patient activity and admission
c.	Reflect on phase 3 categories applied across the STP

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register	x	Multiple COVID risks					
Board Assurance Framework							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 1st October 2020

COVID-19 Overview

1. Community rates

1.1 Increase in community infection rates have been seen in Birmingham and also Sandwell. The rate is lower in Dudley but rising in Wolverhampton. Generally a younger age group and more children are affected. There is now an increase pressure on GP red services (95% capacity) and also on hospital attendances and admissions. There is an increase in cases in the medical wards (focused on respiratory hub at City) and ICU (City site). Close working with Ambulance service continues for conveyance of suspected and positive COVID patients to City site. No paediatric admissions at this time though.

2. Local lock down

2.1 The rule of 6 has been extended in Birmingham and Sandwell to include restrictions on meeting within households or gardens if not within family or support bubbles and greater than 6 people. Schools and universities are back and the potential for increased infection amongst children and young adults is leading to requirements for household isolation. Remember that self-isolation of family members is only needed if their household member/child is infected, but not if they are sent home because of being a contact of a classmate. In these circumstances the child needs to isolate but not the rest of the family. Strict IPC at home is needed in these circumstances but other family members can remain at work (with appropriate social distancing etc.). Swabbing of family members of staff who are symptomatic continues as an offer from the Trust to allow staff members to return to work where swabs are negative.

3. COVID beds

3.1 The Trust still maintains 2 admission streams through ED and AMUs at both sites but aims to concentrate admissions in the substantive bed base on one site (City respiratory hub). Expansion plans are in place for increasing numbers that stay with a focus on City site but also developing options at Sandwell, consequential to service moves from Sandwell to City. This will create greater side room capacity at Sandwell

4. Treatment pathways

4.1 It is important that our treatment pathways established in March/April are applied to COVID admissions. The care of patients in a limited number of areas will allow correct escalation of these pathways, hopefully reducing the risk of admission requirement to ICU. Treatment pathways would include a focus on O_2 therapy escalation (and de-escalation), proning, NIV use on the wards, VTE assessment and prophylaxis, and early use of both steroid (dexamethasone) and anti-virals (remdesivir) as indicated by recent research trial results. These pathways are undergoing urgent review by the relevant clinical teams, with a focus on the NIV service and ICU.

5. New IPC guidance

5.1 The new IPC guidance offers further advice on infection control within hospitals, with a focus on those patients screened, self-isolated and swabbed pre-admission (routine procedure patients – Green wards), separate from those who are acute admissions, where prior infection control procedures were not possible. These patients, placed in an amber category are separated from those with COVID or COVID like symptoms who are in red areas. (See appendix 1). No reference to an intermediate group is made (AKA lilac wards at SWBHT). Though our rate of +ve swabs in lilac patients is low, there is still a requirement for this 'type' of ward which is in effect a mid-point between blue and red wards for those patients with a potential COVID exposure. As the community infection rate increases and the risk of undiagnosed and asymptomatic infection at presentation increases, there is support for the maintenance of the lilac stream for now. This can be continually reassessed as this lilac patient stream does potentially reduce bed capacity if the ward is not full. The lack of side rooms in the Trust means that the lilac stream remains a useful way of isolating patients at greater risk. This lilac capacity is also important where there is now an increased risk of asymptomatic positive patients being identified on the blue stream as the rate of community infection progresses.

6. Swabbing

6.1 The rapid turn around swab (Cepheid) process remains as does the routine swabbing analysis through BCP services at RWT. An additional new system allows for rapid turnaround but also screens for a panel of respiratory viruses and is now available in limited number for the Trust – multiplex system – with a 2 hour turnaround time, 15 viruses are screened for (several coronaviruses, influenza, parainfluenza and RSV as examples) and is suitable for paediatric, ITU and haematology patients initially. Day time use and confirmation of patient to be swabbed is needed. The community service still also provides swabbing for symptomatic household members of staff.

7. Restoration and recovery

7.1 A focus continues on restoration and recovery of services with good progress in many areas of diagnostics and OP provision – much of which is still done by telephone, but increasing use of visionable system amongst colleagues is occurring in some areas. In paediatrics visionable appointments can reduce time out of school, in line with trust quality plan. Further exploration of the use of visionable as well as development of the process to provide access to the consultation for both interpreters and family members needs to occur. Some surgical services have returned to the trust this week and gynae-oncology next week, returning from the independent sector, allowing access to ICU services for post-op recovery where needed.

7.2 PACU (post-anaesthesia care unit) care is being considered as a development to reduce the pressure on ICU and to support care of these patients. This is in addition to training of staff from the gynae ward in level 2 care provided by ITU. In a similar way, new starters to the surgical nursing team have an induction period of 6 weeks on ITU for mentorship and introduction to the Trust while providing them with enhanced clinical care skills to support ward based care.

8. Well-being support

8.1 The support provided to colleagues during the pandemic was well received but it is important to realise the concern that some may have about a return to unfamiliar environments and stressful working practices if needed in the future. The provision of PPE, including silicon FFP3 masks and data showing that those in higher risk areas, but provided with correct equipment, used appropriately have a lower incidence of COVD infection may offer some reassurance. The staff risk assessments, stress assessment and workplace stress assessment are important aspects, as are the well-being resources available within the organisation.

9. Phase 3 submission

9.1 The data submission for restoration and recovery, reflecting projected return of services back to pre COVID capacity is submitted as part of a co-ordinated STP response across the 4 acute Trusts and CCGs. This allows a system based response so that vulnerabilities in each service can be identified and a co-ordinated supportive approach can be taken for those services where pressure is most. There has been a focus on endoscopy as well as other diagnostics but some specialty areas also show commonalities in pressure on achieving a return to normal service where co-working may be possible. The areas are reviewed at the STP clinical reference group comprised of Trust MDs and COOs with project work proposed where acute care collaboration offers likely advantages in return to normal service early and potentially longer term co-ordination of services. The areas of focus in the phase 3 letter were around 4 groups – with a notable focus on improvement in health inequalities as well as return of services and winter planning:

9.1.1 Accelerating the return of non-COVID health services, making full use of the capacity available in the window of opportunity between now and winter.

- Restore full operation of all cancer services.
- Recover the maximum elective activity possible between now and winter, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals.
- Restore service delivery in primary care and community services.
- Expand and improve mental health services and services for people with learning disability and/or autism

9.1.2 Preparation for winter alongside possible COVID resurgence.

- Continue to follow good COVID -related practice to enable patients to access services safely and protect staff, whilst also preparing for localised COVID outbreaks or a wider national wave.
- Preparation for winter

9.1.3 Doing the above in a way that takes account of lessons learned during the first COVID peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.

- Workforce
- Health inequalities and prevention.

9.1.4 Financial arrangements and system working

10. Recommendations

10.1 The Public Trust Board is asked to:

a. Consider new IPC guidance
b. Discuss changes in patient activity and admission
c. Reflect on phase 3 categories applied across the STP

David Carruthers
Medical Director

September 25th 2020

Annex 1: IPC summary
Annex 2: phase 3 summary table

Annex 1:

INFECTION CONTROL DECISION SUPPORT TOOL FOR PLANNED AND UNPLANNED ADMSISSONS

Patients are classed as Low, Medium and High risk. Physical distancing of 2 metres is considered standard practice in all health and care settings. A *staff member may choose to wear higher levels of PPE following their individual risk assessment.*

Low Risk

Planned care surgical / medical patients

All of the following must apply

Patients/individuals with no symptoms

and

A negative COVID-19 SARSCoV-2 PCR test

and

Self-isolated prior to admission

Patients must be cared for in COVID secure, low risk wards : L3 and SAU ,?D21

All Patients on green low risk ward should be re-swabbed every 5 days

Medium Risk

ALL Unplanned Medical and surgical emergency admission

Patients/individuals who have no symptoms of COVID-19 but do not have a COVID-19 SARS- CoV-2 PCR test result and have no known recent COVID-19 contact

or

Asymptomatic individuals who decline testing

If positive swab result move to red high risk ward ASAP

If new or worsening symptoms suggestive of COVID 19. Patient must be re-swabbed immediately by using rapid swab. If the result is positive move to red high risk ward ASAP. If the result is negative, patient to remain where they are unless high clinical suspicion of COVID 19.

All Patients on Amber medium risk ward should be re-swabbed every 5

Medium risk patients must NOT to be transferred to a low risk wards at any stage during the current admission

Contacts of a positive patient are either cohorted on the same ward for 14 days or transferred to the lilac ward for 14days.

High Risk

Any of the following

Confirmed SARS-Cov-2

or

Symptomatic or suspected COID 19

or

History of contact with a COVID 19 case in the last 14 days

If the swab is positive the patient remains on red high risk ward.

If the swab is negative but the clinical presentation is highly suggestive of COVID-19 they remain cohorted on a red ward

After 14 days following a positive COVID 19 test with complete resolution of symptoms, 2 negative swab results 24 hrs apart or 1 negative lower respiratory sample e.g. sputum, is acceptable for stepdown to the Amber /medium risk ward

Negative swabbed patients from a red high risk ward should be transferred to a lilac ward as long as they are clinically unlikely Covid 19.

The PPE requirements for Aerosol generating procedures (AGP) have NOT changed at this time, regardless of the Risk stratification based on symptoms or swab status

NON AGP (*Low, medium & high risk)*

General contact PPE precautions for all staff

- Fluid resistant surgical mask (FRSM)
- Single use Gloves
- Single use Apron (Gown if risk of spraying splashing)
- Eye protection: single use or reusable

AGP (low, *medium & high risk)*

General contact PPE precautions for all staff

- FFP3 respirator (or equivalent)
- Single use Gloves
- Single use Gown
- Eye protection: single use or reusable

Lilac (exposed COVID)

Contact of positive patient will need to isolate for 14days (irrespective of the negative result).

Patient been through the red stream with negative result and has NOT been in contact with any positive patient in the red wards and symptoms have improved/resolved or there is an alternate Non COVID related explanation of the symptoms. **2 negative swab results 72 hrs apart is acceptable for stepdown to the Amber /medium risk**

All Patients in lilac wards should be re-swabbed every 3 days

Annex 2: phase 3 summary table

UI	Key action
A	**Accelerating the return of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter**
A1	A1. Restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021 to:
A1.1	To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.
A1.2	Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:
A1.2.1	Ensuring that sufficient diagnostic capacity is in place in Covid19-secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres
A1.2.2	Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.
A1.2.3	Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
A1.2.4	Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
A1.2.5	Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.
A1.3	Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days.
A2	Recover the maximum elective activity possible between now and winter, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals. Having carefully tested the feasible degree of ambition with a number of trusts and systems in recent weeks, trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:
A2.1	In September at least 80% of their last year's activity for both overnight electives and for outpatient/day case procedures, rising to 90% in October (while aiming for 70% in August);
A2.2	This means that systems need to very swiftly return to at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October.
A2.3	100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).
A2.4	Block payments will flex meaningfully to reflect delivery (or otherwise) against these important patient treatment goals, with details to follow shortly once finalised with Government.

UI	Key action
A2.5	Elective waiting lists and performance should be managed at system as well as trust level to ensure equal patient access and effective use of facilities.
A2.6	Trusts, working with GP practices, should ensure that, between them, every patient whose planned care has been disrupted by COVID receives clear communication about how they will be looked after, and who to contact in the event that their clinical circumstances change.
A2.7	Clinically urgent patients should continue to be treated first, with next priority given to the longest waiting patients, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.
A2.8	To further support the recovery and restoration of elective services, a modified national contract will be in place giving access to most independent hospital capacity until March 2021. The current arrangements are being adjusted to take account of expected usage, and by October/ November it will then be replaced with a re-procured national framework agreement within which local contracting will resume, with funding allocations for systems adjusted accordingly. To ensure good value for money for taxpayers, systems must produce week-by-week independent sector usage plans from August and will then be held directly to account for delivering against them.
A2.9	In scheduling planned care, providers should follow the new streamlined patient self isolation and testing requirements set out in the guideline published by NICE earlier this week. For many patients this will remove the need to isolate for 14 days prior to a procedure or admission.
A2.10	Trusts should ensure their e-Referral Service is fully open to referrals from primary care. To reduce infection risk and support social distancing across the hospital estate, clinicians should consider avoiding asking patients to attend physical outpatient appointments where a clinically-appropriate and accessible alternative exists.
A3	**Restore service delivery in primary care and community services.**
A3.1	General practice, community and optometry services should restore activity to usual levels where clinically appropriate, and reach out proactively to clinically vulnerable patients and those whose care may have been delayed. Dental practices should have now mobilised for face to face interventions. We recognise that capacity is constrained, but will support practices to deliver as comprehensive a service as possible.
A3.2	In restoring services, GP practices need to make rapid progress in addressing the backlog of childhood immunisations and cervical screening through specific catch-up initiatives and additional capacity and deliver through their Primary Care Network (PCN) the service requirements coming into effect on 1 October as part of the Network Contract DES.
A3.3	GPs, primary care networks and community health services should build on the enhanced support they are providing to care homes, and begin a programme of structured medication reviews.
A3.4	CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time. All GP practices must offer face to face appointments at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate – whilst also considering those who are unable to access or engage with digital services.
A3.5	Community health services crisis responsiveness should be enhanced in line with the goals set out in the Long Term Plan, and should continue to support patients who have recovered from the acute phase of COVID but need ongoing rehabilitation and other community health services. Community health teams should fully resume appropriate and safe home visiting care for all those vulnerable/shielding patients who need them.

UI	Key action
A3.6	The Government is continuing to provide funding to support timely and appropriate discharge from hospital inpatient care in line with forthcoming updated Hospital Discharge Service Requirements. From 1 September 2020, hospitals and community health and social care partners should fully embed the discharge to assess processes. New or extended health and care support will be funded for a period of up to six weeks, following discharge from hospital and during this period a comprehensive care and health assessment for any ongoing care needs, including determining funding eligibility, must now take place. The fund can also be used to provide short term urgent care support for those who would otherwise have been admitted to hospital.
A3.7	The Government has further decided that CCGs must resume NHS Continuing Healthcare assessments from 1 September 2020 and work with local authorities using the trusted assessor model. Any patients discharged from hospital between 19 March 2020 and 31 August 2020, whose discharge support package has been paid for by the NHS, will need to be assessed and moved to core NHS, social care or self-funding arrangements.
A4	**Expand and improve mental health services and services for people with learning disability and/or autism**
A4.1	Every CCG must continue to increase investment in mental health services in line with the Mental Health Investment Standard and we will be repeating the independent audits of this. Systems should work together to ensure that funding decisions are decided in partnership with Mental Health Providers and CCGs and that funding is allocated to core Long Term Plan (LTP) priorities.
A4.2	In addition, we will be asking systems to validate their existing LTP mental health service expansion trajectories for 2020/21. Further advice on this will be issued shortly. In the meantime:
A4.2.1	IAPT services should fully resume
A4.2.2	The 24/7 crisis helplines for all ages that were established locally during the pandemic should be retained, developing this into a national service continue the transition to digital working
A4.2.3	Maintain the growth in the number of children and young people accessing care
A4.2.4	Proactively review all patients on community mental health teams' caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with SMI in the community;
A4.2.5	Ensure that local access to services is clearly advertised
A4.2.6	Use £250 million of earmarked new capital to help eliminate mental health dormitory wards.
A4.3	In respect of support for people with a learning disability, autism or both:
A4.3.1	Continue to reduce the number of children, young people and adults within a specialist inpatient setting by providing better alternatives and by ensuring that Care (Education) and Treatment Reviews always take place both prior to and following inpatient admission.
A4.3.2	Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020.
A4.3.3	GP practices should ensure that everybody with a Learning Disability is identified on their register; that their annual health checks are completed; and access to screening and flu vaccinations is proactively arranged. (This is supported by existing payment arrangements and the new support intended through the Impact and Investment Fund to improve uptake.)
B	**Preparation for winter alongside possible COVID resurgence.**

UI	Key action
B1	**Continue to follow good COVID -related practice to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave. This includes:**
B1.1	Continuing to follow PHE's guidance on defining and managing communicable disease outbreaks.
B1.2	Continue to follow PHE/DHSC-determined policies on which patients, staff and members of the public should be tested and at what frequency, including the further PHE-endorsed actions set out on testing on 24 June. All NHS employers should prepare for the likelihood that if background infection risk increases in the Autumn, and DHSC Test and Trace secures 500,000+ tests per day, the Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine Covid testing of all asymptomatic staff across the NHS.
B1.3	Ongoing application of PHE's infection prevention and control guidance and the actions set out in the letter from 9 June on minimising nosocomial infections across all NHS settings, including appropriate Covid-free areas and strict application of hand hygiene, appropriate physical distancing, and use of masks/face coverings.
B1.4	Ensuring NHS staff and patients have access to and use PPE in line with PHE's recommended policies, drawing on DHSC's sourcing and its winter/EU transition PPE and medicines stockpiling.
B2	**Prepare for winter including by:**
B2.1	Sustaining current NHS staffing, beds and capacity, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.
B2.2	Deliver a very significantly expanded seasonal flu vaccination programme for DHSC-determined priority groups, including providing easy access for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine if and when a vaccine becomes available.
B2.3	Expanding the 111 First offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty 'hot' clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres (UTCs). DHSC will shortly be releasing agreed A&E capital to help offset physical constraints associated with social distancing requirements in Emergency Departments.
B2.4	Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.
B2.5	Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.
B2.6	Continuing to work with local authorities, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/PHE policies (see A3 above).
C	**Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.**
C1	**Workforce**

UI	Key action
C1.1	COVID-19has once again highlighted that the NHS, at its core, is our staff. Yesterday we published We are the NHS: People Plan for 2020/21 (https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/) - actions for us all which reflects the strong messages from NHS leaders and colleagues from across the NHS about what matters most. It sets out practical actions for employers and systems, over the remainder of 2020/21 ahead of Government decisions in the Autumn Spending Review on future education and training expansions. It includes specific commitments on:
C1.2	Actions all NHS employers should take to keep staff safe, healthy and well – both physically and psychologically.
C1.3	Specific requirements to offer staff flexible working.
C1.4	Urgent action to address systemic inequality that is experienced by some of our staff, including BAME staff.
C1.5	New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.
C1.6	Growing our workforce, building on unprecedented interest in NHS careers. It also encourages action to support former staff to return to the NHS, as well as taking steps to retain staff for longer – all as a contribution to growing the nursing workforce by 50,000, the GP workforce by 6,000 and the extended primary care workforce by 26,000.
C1.7	Workforce planning and transformation that needs to be undertaken by systems to enable people to be recruited and deployed across organisations, sectors and geographies locally.
C1.8	All systems should develop a local People Plan in response to these actions, covering expansion of staff numbers, mental and physical support for staff, improving retention and flexible working opportunities, plus setting out new initiatives for development and upskilling of staff. Wherever possible, please work with local authorities and local partners in developing plans for recruitment that contribute to the regeneration of communities, especially in light of the economic impact of Covid. These local People Plans should be reviewed by regional and system People Boards, and should be refreshed regularly.
C2	**Health inequalities and prevention.**
C2.1	We are asking you to work collaboratively with your local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and regularly assess this progress. Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:
C2.3	Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.
C2.4	Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.
C2.5	Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes. This should include more accessible flu vaccinations, the better targeting of long-term condition prevention and management programmes, obesity reduction programmes including self-referral to the NHS Diabetes Prevention Programme, health checks for people with learning disabilities, and increasing the continuity of maternity carers including for BAME women and those in high risk groups.

UI	Key action
C2.6	Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.
C2.7	Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later 31 December, with general practice prioritising those groups at significant risk of COVID19 from 1 September.
D1	**Financial arrangements and system working**
D1.1	To support restoration, and enable continued collaborative working, current financial arrangements for CCGs and trusts will largely be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government. More detail is set out in Annex Two. Working across systems, including NHS, local authority and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:
D1.2	Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.
D1.3	Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed governance and decision-making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.
D1.4	Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.
D1.5	A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health.