Phase three letter - SFHFT

Action	Exec lead	Reporting where	
		Exec Cttee	Board Cttee
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.	JH/ DS	NMAHP Board Executive team	Quality Committee
2 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	SB	Recovery Group TMT Executive team	Recovery committee
3 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.	SB	Recovery Group TMT Executive team	Recovery committee
4 Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.	SB	Recovery Group TMT Executive team	Recovery committee
5 Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.	JH	NMAHP Board Executive team	Quality Committee
6 Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.	SB	Recovery Group TMT Executive team	Recovery committee
7 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.	SB	Recovery Group TMT Executive team	Recovery committee

8	In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October (while aiming for 70% in August);	SB	Recovery Group TMT Executive team	Recovery committee
9	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.	SB	Recovery Group TMT Executive team	Recovery committee
10	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).	SB	Recovery Group TMT Executive team	Recovery committee
11	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.	RS	Recovery TMT Execs	Recovery committee
12	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.	SB	Recovery Group TMT Executive team	Recovery committee
13	Trusts should ensure their e-Referral Service is fully open to referrals from primary care.	SB	Recovery Group TMT Executive team	Recovery committee
14	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. Healthwatch have produced useful advice on how to support patients in this way. This means collaboration between primary and secondary care to use advice and guidance where possible and treat patients without an onward referral, as well as giving patients more control over their outpatient follow-up care by adopting a patient-initiated follow-up approach across major outpatient specialties.	DS	Outpatient Transformation Programme	Quality Committee

15 Where an outpatient appointment is clinically necessary, the national benchmark is that at least 25% could be conducted by telephone or video including 60% of all follow-up appointments.	DS/ SB	Outpatient Transformation Programme	Recovery Committee
16 Continuing to follow PHE's guidance on defining and managing communicable disease outbreaks.	DS	Outbreak Management Group Incident control team	Quality Committee
17 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.	DS	Incident control team	Recovery Committee
18 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.	DS	Outbreak Management Group Incident control team	Quality Committee
19 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.	PR	Incident Control Team TMT Executive team	Trust Board
20 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.	SB	TMT Executive team	
21 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.	DS/ JH	TMT Executive team	Quality Committee

22 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.	EC/ DS/ JH	TMT Executive team	Quality Committee
23 Actions all NHS employers should take to keep staff safe, healthy and well – both physically and psychologically.	CT / EC	People and Inclusion Cabinet Culture and Improvement Cabinet	People Improvement and Culture Committee
24 Specific requirements to offer staff flexible working.	CT	People and Inclusion Cabinet	People Improvement and Culture Committee
25 Urgent action to address systemic inequality that is experienced by some of our staff, including BAME staff.	CT	People and Inclusion Cabinet	People Improvement and Culture Committee
26 New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.	CT	People and Inclusion Cabinet	People Improvement and Culture Committee
27 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.	JH	NMAHP Board Executive team	Quality Committee
28 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.	DS	Digital Strategy Group	Recovery committee
29 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.	JH & DS	QPSC	Quality Committee
30 Strengthen leadership and accountability, with a named executive Board member responsible for		People and Inclusion	People Improvement

	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.		Cabinet	and Culture Committee
31	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.	JH	NMAHP Board	Quality Committee