# NHS Rotherham CCG Governing Body – September 2020

**CHIEF OFFICER'S REPORT**

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|---|---|---|---|
| Lead Director: | **Chris Edwards** | Lead Officer: | n/a |
| Job Title: | **CCG Chief Officer** | Job Title: | n/a |

**Purpose**
This report informs the Governing Body about national/local developments in the past month.

**NHS Letter – Phase 3**

I have attached as appendix 1 a letter I have received from Sir Simon Stevens & Amanda Pritchard in regards to the third phase of the NHS response to Covid-19, which is effective from the 1st August 2020.

This letter outlines the NHS priorities from August. The shared focus is on:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the "window of opportunity" between now and winter.
B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.
C. Doing the above in a way that takes account of lessons learner during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

**CCG Governance**

You may remember back at our meeting in April we suspended the CCG standing orders, which in effect suspended our Governance in line with the requirements of the National Command and Control system which was in place from NHSE. We originally said this would be for a period of 12 weeks. It has been slightly longer than that but with the previous lowering of the national pandemic from a Level 4 incident to a Level 3, I propose, as from today, we will revert to full CCG Governance.

**Action: GB to agree to return to full Governance**

**Prescribing Incentive Scheme**

Primary Care Committee reviewed the NHS Rotherham CCG Prescribing Incentive Scheme Payments 2019/20 papers on the 12 August 2020 under confidential setting, and were assured that the principles and methodology were appropriate, and stand up to scrutiny for payment of the 2019/20 programme.

**National Flu Letter**

Appendix 2 is a letter updating me with more information about this year's national flu immunisation programme. The letter covers issues such as vaccine supply, vaccine uptake ambition etc. The letter also informs of an extension to the current programme and confirms the programme is being extended to:

- household contacts of those on the NHS Shielded Patient List. Specifically individuals who expect to share living accommodation with a shielded person on most days over the winter and therefore for whom continuing close contact is unavoidable.
- children of school Year 7 age in secondary schools (those aged 11 on 31 August 2020).

- health and social care workers employed through Direct Payment (personal budgets) and/or Personal Health Budgets, such as Personal Assistants, to deliver domiciliary care to patients and service users

As well as a possible extension to those in the 50-60 year old age group subject to vaccine supply.

**Communications Update**

- Communications activity with the CCG and wider NHS is now switching to a focus on service recovery and encouraging patients to access support and advice where appropriate. This activity will run alongside the continuation of messages relating to COVID-19, such as advice on national guidelines, how to access services and what to do if you have symptoms.

- Mental health communications continue with further development of Rotherhive (online platform). As we continue to further understand key areas resulting from the pandemic we will be introducing new sections of the site, which will help both professionals and the public to access the help they need through a digital platform. Rotherhive forms a key element of the mental health and wellbeing offer in Rotherham, which also includes both prevention and services support.

- A winter communications campaign is currently being developed to support local residents and the health and care system over the coming months. Key elements of the campaign will include promotion of the flu vaccine (staff and the public), think NHS 111 first, mental health and availability of health services in the community throughout winter.

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*From the Chief Executive Sir Simon Stevens*
*& Chief Operating Officer Amanda Pritchard*

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Regional Incident Directors & Heads of EPRR
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

31 July 2020

Dear Colleague

**IMPORTANT – FOR ACTION – THIRD PHASE OF NHS RESPONSE TO COVID-19**

We are writing to thank you and your teams for the successful NHS response in the face of this unprecedented pandemic, and to set out the next – third – phase of the NHS response, effective from 1 August 2020.

You will recollect that on 30th January NHS England and NHS Improvement declared a Level 4 National Incident, triggering the first phase of the NHS pandemic response. Since then the NHS has been able to treat every coronavirus patient who has needed specialist care – including 107,000 people needing emergency hospitalisation. Even at the peak of demand, hospitals were still able to look after two non-Covid inpatients for every one Covid inpatient, and a similar picture was seen in primary, community and mental health services.

As acute Covid pressures were beginning to reduce, we wrote to you on 29 April to outline agreed measures for the second phase, restarting urgent services. Now in this Phase Three letter we:

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

**Current position on Covid-19**

On 19 June 2020 the Chief Medical Officers and the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level from four to three, signifying that the virus remains in general circulation with localised outbreaks likely to occur. On 17 July the Government set out next steps including the role of the new Test and Trace programme in providing us advance notice of any expected surge in Covid demand, and in helping manage local and regional public health mitigation measures to prevent national resurgence.

Fortunately, Covid inpatient numbers have now fallen nationally from a peak of 19,000 a day, to around 900 today. As signalled earlier this month, the current level of Covid demand on the NHS means that the Government has agreed that the NHS EPRR incident level will move from Level 4 (national) to Level 3 (regional) with effect from tomorrow, 1 August. This approach matches the differential regional measures the Government is deploying, including today in parts of the North West and North East. The main implications of this are set out in Annex One to this letter.

However Covid remains in general circulation and we are seeing a number of local and regional outbreaks across the country, with the risk of further national acceleration. Together with the Joint Biosecurity Centre and Public Health England (PHE) we will therefore continue to keep the situation under close review, and will not hesitate to reinstate the Level 4 national response immediately as circumstances justify it. In the meantime NHS organisations will need to retain their EPRR incident coordination centres and will be supported by oversight and coordination by Regional Directors and their teams.

**NHS priorities from August**

Having pulled out all the stops to treat Covid patients over the last few months, our health services now need to redouble their focus on the needs of all other patients too, while recognising the new challenges of overcoming our current Covid-related capacity constraints. This will continue to require excellent collaboration between clinical teams, providers and CCGs operating as part of local 'systems' (STPs and ICSs), local authorities and the voluntary sector, underpinned by a renewed focus on patient communication and partnership.

Following discussion with patients' groups, national clinical and stakeholder organisations, and feedback from our seven regional 'virtual' frontline leadership meetings last week, we are setting out NHS priorities for this third phase. Our shared focus is on:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

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, and action on inequalities and prevention.

As part of this Phase Three work, and following helpful engagement and discussion, alongside this letter yesterday we published a more detailed 2020/21 People Plan, and will shortly do the same on

inequalities reduction. DHSC are also expected to set out equivalent phase three priorities and support for social care.

Nationally, we will work with the wide range of stakeholders represented on the NHS Assembly to help track and challenge progress against these priorities. As we do so it is vital that we listen and learn from patients and communities. We ask that all local systems act on the Five principles for the next phase of the Covid-19 response developed by patients' groups through National Voices.

## 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. **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:**

- 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.

- Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:

  - 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
  - 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.
  - Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
  - Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
  - Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.

- 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.

In setting clear performance expectations there is a careful balance to be struck between the need to be ambitious and stretching for our patients so as to avoid patient harm, while setting a performance level that is deliverable, recognising that each trust will have its own particular pattern of constraints to overcome.

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:

- **In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October** (while aiming for 70% in August);

- This means that systems need to very swiftly return to **at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October**.

- **100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).**

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.

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.

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.

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.

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.

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.

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. 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. 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.

A3. **Restore service delivery in primary care and community services.**

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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**

- 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.

- 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:
  - IAPT services should fully resume
  - 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
  - maintain the growth in the number of children and young people accessing care
  - 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;
  - ensure that local access to services is clearly advertised
  - use £250 million of earmarked new capital to help eliminate mental health dormitory wards.

- In respect of support for people with a **learning disability, autism or both**:
  - 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.
  - Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020.
  - 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.

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:

- Continuing to follow PHE's guidance on defining and managing communicable disease **outbreaks**.

- 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.

- 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.

- 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:

- 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.

- 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.

- 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.

- 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.

- 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.

- 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**

Covid19 has once again highlighted that the NHS, at its core, is our staff. Yesterday we published We are the NHS: People Plan for 2020/21 - 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:

- Actions all NHS employers should take to keep staff safe, healthy and well – both physically and psychologically.
- Specific requirements to offer staff flexible working.
- Urgent action to address systemic inequality that is experienced by some of our staff, including BAME staff.
- New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.
- 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.
- 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.

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.**

Covid has further exposed some of the health and wider inequalities that persist in our society. The virus itself has had a disproportionate impact on certain sections of the population, including those living in most deprived neighbourhoods, people from Black, Asian and minority ethnic communities, older people, men, those who are obese and who have other long-term health conditions and those in certain occupations. It is essential that recovery is planned in a way that inclusively supports those in greatest need.

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:

- 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.

- 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.

- 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.

- 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.

- 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.

**Financial arrangements and system working**

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:

- 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.

- 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.

- 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.

- 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.

Finally, we are asking you – working as local systems - to return a draft **summary plan by 1 September** using the templates issued and covering the key actions set out in this letter, with **final plans due by 21 September**. These plans need to be the product of partnership working across STPs/ICSs, with clear and transparent triangulation between commissioner and provider activity and performance plans.

Over the last few months, the NHS has shown an extraordinary resilience, capacity for innovation and ability to move quickly for our patients. Like health services across Europe, we now face the double challenge of continuing to have to operate in a world with Covid while also urgently responding to the many urgent non-Covid needs of our patients. If we can continue to harness the same ambition, resilience, and innovation in the second half of the year as we did in the first, many millions of our fellow citizens will be healthier and happier as a result. So thank you again for all that you and your teams have been – and are – doing, in what is probably the defining year in the seven-decade history of the NHS.

With best wishes,

Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

## ANNEX ONE: IMPLICATIONS OF EPRR TRANSITION TO A LEVEL 3 INCIDENT

As previously signalled, effective 1 August 2020 the national incident level for the Covid19 response will change from level 4 (an incident that requires NHS England National Command and Control to support the NHS response) to level 3 (an incident that requires the response of a number of health organisations across geographical areas within an NHS England region), until further notice.

It is entirely possible that future increases in Covid demands on the NHS mean that the level 4 incident will need to be reinstated. In which case, there will be no delay in doing so. However this change does, for the time being, provide the opportunity to focus local and regional NHS teams on accelerating the restart of non-Covid services, while still preparing for a possible second national peak.

The implications of the transition from a level 4 to level 3 incident are as follows:

- *Oversight*: Transition from a national command, control and coordination structure to a regional command, control and coordination structure but with national oversight as this remains an incident of international concern.

- *Reporting*: We will be stopping weekend sit rep collections from Saturday 8 August 2020 (Saturday and Sunday data will be collected on Mondays with further detail to follow). Whilst we are reducing the incident level with immediate effect reports will still be required this weekend (1 and 2 August 2020) and we will subsequently need to be able to continue to align to DHSC requirements. Additional reporting will be required for those areas of the country experiencing community outbreaks in line with areas of heightened interest, concern or intervention.

- *Incident coordination functions*: The national and regional Incident Coordination Centres will remain in place (hours of operation may be reduced). The frequency of national meetings will decrease (for example IMT will move to Monday, Wednesday, Friday). Local organisations should similarly adjust their hours and meeting frequency accordingly. It is however essential that NHS organisations fully retain their incident coordination functions given the ongoing pandemic, and the need to stand up for local incidents and outbreaks.

- *Communications:* All communications related to Covid19 should continue to go via established Covid19 incident management channels, with NHS organisations not expected to respond to incident instructions received outside of these channels. Equally, since this incident continues to have an international and national profile, it is important that our messaging to the public is clear and consistent. You should therefore continue to coordinate communications with your regional NHS England and NHS Improvement communications team. This will ensure that information given to the media, staff and wider public is accurate, fully up-to-date and aligns with national and regional activity.

## ANNEX TWO: REVISED FINANCIAL ARRANGEMENTS

The current arrangements comprise nationally-set block contracts between NHS providers and commissioners, and prospective and retrospective top-up funding issued by NHSE/I to organisations to support delivery of breakeven positions against reasonable expenditure. The M5 and M6 block contract and prospective top-up payments will be the same as M4. Costs of testing and PPE will continue to be borne centrally for trusts and general practices funded by DHSC who continue to lead these functions for the health and social care sectors.

The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government.

The revised framework will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and the restoration of elective services. The intention is that systems will be issued with funding envelopes comprising funding for NHS providers equivalent in nature to the current block and prospective top-up payments and a system-wide Covid funding envelope. There will no longer be a retrospective payment mechanism. Providers and CCGs must achieve financial balance within these envelopes in line with a return to usual financial disciplines. Whilst systems will be expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions. The funding envelopes will comprise:

- CCG allocations – within which block contract values for services commissioned from NHS providers within and outside of the system will continue to be nationally calculated;

- Directly commissioned services from NHS providers – block contract values for specialised and other directly commissioned services will continue to be nationally calculated;

- Top-up – additional funding to support delivery of a breakeven position; and

- Non-recurrent Covid allocation – additional funding to cover Covid-related costs for the remainder of the year.

Funding envelopes will be calculated on the basis of full external income recovery. For relationships between commissioners and NHS providers we will continue to operate nationally calculated block contract arrangements. For low-volume flows of CCG-commissioned activity, block payments of an appropriate value would be made via the Trust's host CCG; this will remove the need for separate invoicing of non-contract activity.

However block payments will be adjusted depending on delivery against the activity restart goals set in Section A1 and A2 above.

Written contracts with NHS providers for the remainder of 2020/21 will not be required.

For commissioners, non-recurrent adjustments to commissioner allocations will continue to be actioned – adjustments to published allocations will include any changes in contracting responsibility and distribution of the top-up to CCGs within the system based on target allocation.

Reimbursement for high cost drugs under the Cancer Drugs Fund (CDF) and relating to treatments under the Hepatitis C programme will revert to a pass-through cost and volume basis, with adjustments made to NHS provider block contract values to reflect this. For the majority of other high cost drugs and devices, in-year provider spend will be tracked against a notional level of spend

included in the block funding arrangements with adjustments made in-year to ensure that providers are reimbursed for actual expenditure on high cost drugs and devices. This will leave a smaller list of high cost drugs which will continue to be funded as part of the block arrangements.

In respect of Medical pay awards, on 21 July 2020 the Government confirmed the decision to uplift pay in 2020/21 by 2.8% for consultants, specialty doctors and associate specialists, although there is no uplift to the value of Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points for 2020/21. We expect this to be implemented in September pay and backdated to April 2020. In this event, NHS providers should claim the additional costs in September as part of the retrospective top-up process. Future costs will be taken into account in the financial framework for the remainder of 2020/21, with further details to be confirmed in due course.

Department of Health & Social Care

Public Health England

NHS

Tuesday 4 August 2020

Dear Colleague,

## The national flu immunisation programme 2020 to 2021- update

1. We write with more information about this year's programme, further to the letter published on 14 May[1].

## Expansion of the programme

2. In light of the risk of flu and COVID-19 co-circulating this winter, the national flu immunisation programme will be absolutely essential to protecting vulnerable people and supporting the resilience of the health and care system.

3. As indicated in our letter of 14 May, providers should focus on achieving maximum uptake of the flu vaccine in existing eligible groups, as they are most at risk from flu or in the case of children transmission to other members of the community. Appendix A provides the full list of those eligible in 2020/21 as part of the NHS funded flu vaccination programme. This includes individuals meeting existing flu eligibility criteria.

4. This year as part of our wider planning for winter, and subject to contractual negotiations, this season flu vaccination will be additionally offered to:

   - household contacts of those on the NHS Shielded Patient List. Specifically individuals who expect to share living accommodation with a shielded person on most days over the winter and therefore for whom continuing close contact is unavoidable.
   - children of school Year 7 age in secondary schools (those aged 11 on 31 August 2020).
   - health and social care workers employed through Direct Payment (personal bugets) and/or Personal Health Budgets, such as Personal Assistants, to deliver domiciliary care to patients and service users

5. We aim to further extend the vaccine programme in November and December to include the 50-64 year old age group subject to vaccine supply. This extension is being phased to allow you to prioritise those in at risk groups first. Providers will be

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/885281/The_national_flu_immunisation_programme_2020_to_2021.pdf



PHE Gateway Ref: 2020153
NHS England Publishing Approval Reference: B0096

given notice in order to have services in place for any additional cohorts later in the season.

6. Department of Health and Social Care (DHSC) is exploring options to expand the workforce that is able to administer vaccinations as part of the COVID-19 response. Key stakeholders and the public will be consulted on the proposed changes over summer, including via stakeholder meetings. In line with the government's consultation principles, the consultation will be published on gov.uk in due course and will clearly set out the policy proposals.

7. Building on good practice from previous flu seasons and to reflect the need to achieve maximum coverage this year, all Hospital Trusts will be asked to offer vaccinations to pregnant women attending maternity appointments and to those clinically at risk eligible patients attending in- and out-patient appointments. National service specifications will be developed to support the standardised commissioning of these services.

8. In addition, this season an inactivated vaccine may be offered to those children whose parents refuse the live attenuated influenza vaccine (LAIV) due to the porcine gelatine content, in order to prevent localised outbreaks this year. Providers of children's vaccination services will receive further instruction on the offering of this service in due course.

9. It is essential to increase flu vaccination levels for those who are living in the most deprived areas and from BAME communities. We need to ensure equitable uptake compared to the population as a whole and help protect those who are more at risk if they are to get COVID-19 and flu. It will therefore require high quality, dedicated and culturally competent engagement with local communities, employers and faith groups.

10. Providers are expected to ensure they have robust plans in place for tackling health inequalities for all underserved groups to ensure equality of access.

11. Individuals eligible for flu vaccine this season should be offered a vaccine recommended for them according to their age, as detailed in Appendix B.

## Frontline health and social care workers

12. All frontline health and social care workers should receive a vaccination this season. This should be provided by their employer, in order to meet their responsibility to protect their staff and patients and ensure the overall safe running of services. **Employers should commission a service which makes access easy to the vaccine for all frontline staff, encourage staff to get vaccinated, and monitor the delivery of their programmes.**

13. For healthcare workers providers should use the current definition as set out in chapter 12 of the Green Book. https://www.gov.uk/government/publications/immunisation-of-healthcare-and-laboratory-staff-the-green-book-chapter-12

14. NHS Trusts should complete a self-assessment against a best practice checklist which has been developed based on five key components of developing an effective flu vaccination programme. The completed checklist should be published in public board papers at the start of the flu season. See Appendix C.

15. NHS England and Improvement (NHSEI) will continue to support vaccination of social care and hospice workers employed by registered residential or domiciliary care providers. The eligible groups have been expanded this year to include those health and social care workers, such as Personal Assistants, employed through Direct Payment and/or Personal Health Budgets to deliver domiciliary care to patients and service users. Vaccination will be available through community pharmacy or their registered general practice. This scheme is intended to complement, not replace, any established occupational health schemes that employers have in place to offer flu vaccination to their workforce. Further guidance on how providers can ensure their employees get vaccinated will be published shortly.

16. The Community Pharmacy Seasonal Influenza Advanced Service Framework will be amended to enable community pharmacies to vaccinate both residential care/nursing home residents and staff in the home setting in a single visit to increase uptake rates and offer further protection to this vulnerable group of patients. GP practices are also able to vaccinate in the residential/care home, residents and staff who are registered with the practice.

17. Good practice guidance along with a range of resource material can be found here: www.england.nhs.uk/increasing-health-and-social-care-worker-flu-vaccinations/. Further updates are underway to include additional resources which will be made available ahead of the flu season this year.

## Vaccine supply

18. As usual, providers will have ordered flu vaccine directly from manufacturers. This season, we are expecting increased demand for flu vaccine across all cohorts and we are also expanding the flu programme. To support this, the Department of Health and Social Care (DHSC) has procured additional national supply of the adult vaccine and will issue guidance in September on how and when this can be accessed.

19. Two of the vaccines for use in the children's programme have been procured by Public Health England (PHE) and PHE has procured additional stock for this season.These are the live attenuated influenza vaccine (LAIV) administered as a nasal spray and

suitable for use in children aged 2 to less than 18 years except where contraindicated, and the injectable egg-grown Quadrivalent Influenza Vaccine (QIVe) for children in clinical risk groups for whom LAIV is unsuitable due to contraindication or age. These vaccines can be accessed through Immform at https://portal.immform.phe.gov.uk.

20. For eligible children from 9 years of age unable to receive LAIV, locally procured QIVc and QIVe are alternatively able to be given. For further information see Appendix E and www.england.nhs.uk/wp-content/uploads/2019/12/NHS-England-JCVI-advce-and-NHS-reimbursement-flu-vaccine-2020-21.pdf

## Flu vaccine uptake ambitions

21. This year, we are asking for a concerted effort to significantly increase flu vaccination coverage and achieve a minimum 75% uptake across all eligible groups. Where possible, we expect uptake will be higher than this and a national supply of stock has been procured to ensure demand does not outstrip supply.

22. Many of the groups who are vulnerable to flu are also more vulnerable to COVID-19. Not only do we want to help protect those most at risk of flu, but also protect the health of those who are vulnerable to hospitalisation and death from COVID-19 by ensuring they do not get flu. The table below sets out the ambitions for 2020/21:

**Table 1: Vaccine uptake ambitions in 2020 to 2021**

| Eligible groups | Uptake ambition |
|---|---|
| Aged 65 years and over | **At least 75%** |
| In clinical at risk group | **At least 75%** |
| Pregnant women | **At least 75%** |
| Children aged 2 and 3 year old | **At least 75%** |
| All primary school aged children and school year 7 in secondary school | **At least 75%** |
| Frontline health and social care workers | **100% offer** |

23. Household contacts of people on the NHS Shielded Patient list will not be subject to call and recall arrangements but will be offered the vaccine opportunistically, with the aim to offer to all identified.

24. NHSEI are developing a national call and recall service to support localised call and recall provision and ensure that all eligible patients are informed of their eligibility and are encouraged to get vaccination this season. This service is intended to supplement not replace local call and recall mechanisms that are already in place contractually.

## Delivering the programme during the pandemic

25. Patients will, need reassurance that appropriate measures are in place to keep them safe from COVID-19, as it is likely to be co-circulating with flu. This reassurance will be especially important for those on the NHS Shielded Patient List.

26. Providers will be expected to deliver the programme according to guidelines on social distancing that are current at the time. Standard operating procedures in the context of COVID-19 have been issued for General Practice, community pharmacy, and community health services:

    www.england.nhs.uk/coronavirus/publication/managing-coronavirus-covid-19-in-general-practice-sop/

    www.england.nhs.uk/coronavirus/publication/standard-operating-procedure-community-pharmacy/

    www.england.nhs.uk/coronavirus/publication/covid-19-prioritisation-within-community-health-services-with-annex_19-march-2020/

    www.england.nhs.uk/coronavirus/publication/novel-coronavirus-covid-19-standard-operating-procedure-community-health-services/

27. For guidance on immunisation during COVID-19, including personal protective equipment, see: 'Clinical Guidance for Healthcare professionals on maintaining immunisation programmes during COVID-19' at: www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/06/clinical-guidance-for-hcps-on-imms-for-covid-19.pdf

28. These procedures and guidance mean that a range of different ways of delivering the flu immunisation programme this year should be considered including the following:

    - careful appointment planning to minimise waiting times and maintain social distancing when attending
    - providing patients with information in advance of their appointment to explain what to expect
    - recalling at risk patients if they do not attend in line with contract requirements
    - social distancing innovations such as drive in vaccinations and 'car as waiting room' models, if possible
    - for those on the Shielded Patient List who are high risk for COVID-19 consider the use of domiciliary visits

29. For the overall schools vaccination programme social distancing measures will create additional challenges, and where possible we still expect the school estate to be used in the event of any local school closures.

30. Providers need to be prepared to make adjustments to the programme in the face of any local restrictions to ensure those at highest risk can continue to be vaccinated.

31. We are also considering supporting delivery through standing up alternative delivery approaches, to maximise coverage of the vaccine this winter.

## Infection prevention and control when administering vaccines

32. Individuals should attend for vaccination at premises that are following the recommended infection prevention and control (IPC) guidance. www.england.nhs.uk/coronavirus/primary-care/infection-control/

33. Those displaying symptoms of COVID-19, or who are self-isolating because they are confirmed COVID-19 cases or are contacts of suspected or confirmed COVID-19 cases, should not attend until they have recovered and completed the required isolation period.

34. Further information regarding infection prevention and control measures can be found in the 'Information for Healthcare Practitioner' documents, which will be updated prior to and during the season as required, and are available at: www.gov.uk/government/collections/annual-flu-programme

35. Healthcare professionals administering the vaccine will need to wear the recommended personal protective equipment that is in line with the current advice from the government: www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe

## Communications and Marketing

36. The flu vaccination programme will be supported with a major new public facing marketing campaign to encourage take up amongst eligible groups for the free flu vaccine, due to launch in October. More detailed plans will be shared as these are developed.

37. PHE will make available a toolkit of adaptable campaign assets, highlighting the protective benefits of the flu vaccination, for NHS Trusts and social care organisations to use in their own staff vaccination campaigns.

38. Resources for both campaigns will be available to download and order from the PHE Campaign Resource Centre at: https://campaignresources.phe.gov.uk/resources/

## List of appendices

39. Detailed planning information is set out in the following appendices:


Appendix A: Groups included in the national immunisation programme page 9
Appendix B: Summary table of which influenza vaccines to offer page 11
Appendix C: Healthcare worker best practice management checklist page 12
Appendix D: Children's flu vaccination programme page 14
Appendix E: Vaccine ordering for children's programme page 16
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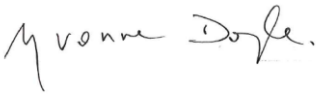
Appendix G: Data collection page 19
Appendix H: Antiviral medicines page 21


## Conclusion

40. This year, more than ever, we need to protect those most at risk from flu. Thank you for all your hard work in these very challenging times.

41. This Annual Flu Letter has the support of the Chief Pharmaceutical Officer, the NHS Chief Nursing Officer for England and the Public Health England Chief Nurse.

Yours sincerely,



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Any enquiries regarding this publication should be sent to: immunisation@phe.gov.uk. For operational immunisation queries, providers should contact their local screening and immunisation team.

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National Care Forum (NCF)
National Care Association (NCA)
Care England
ADASS (Association of Directors of Adult Social Services)
Local Government Association
Unison

## Appendix A: Groups included in the national flu immunisation programme

1. In 2020/21, flu vaccinations will be offered under the NHS flu vaccination programme to the following groups:

   - all children aged two to eleven (but not twelve years or older) on 31 August 2020
   - people aged 65 years or over (including those becoming age 65 years by 31 March 2021)
   - those aged from six months to less than 65 years of age, in a clinical risk group such as those with:
     - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
     - chronic heart disease, such as heart failure
     - chronic kidney disease at stage three, four or five
     - chronic liver disease
     - chronic neurological disease, such as Parkinson's disease or motor neurone disease,
     - learning disability
     - diabetes
     - splenic dysfunction or asplenia
     - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)
     - morbidly obese (defined as BMI of 40 and above)
   - all pregnant women (including those women who become pregnant during the flu season)
   - household contacts of those on the NHS Shielded Patient List, or of immunocompromised individuals, specifically individuals who expect to share living accommodation with a shielded patient on most days over the winter and therefore for whom continuing close contact is unavoidable
   - people living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. This does **not** include, for instance, prisons, young offender institutions, university halls of residence, or boarding schools (except where children are of primary school age or secondary school Year 7).
   - those who are in receipt of a carer's allowance, or who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill
   - health and social care staff, employed by a registered residential care/nursing home or registered domiciliary care provider, who are directly involved in the care of vulnerable patients/clients who are at increased risk from exposure to influenza.

- health and care staff, employed by a voluntary managed hospice provider, who are directly involved in the care of vulnerable patients/clients who are at increased risk from exposure to influenza.

- health and social care workers employed through Direct Payments (personal budgets) and/or Personal Health Budgets, such as Personal Assistants, to deliver domiciliary care to patients and service users.

2. Additionally, in 2020/21, flu vaccinations might be offered under the NHS flu vaccination programme to the following groups:

    - individuals between 50-64 years, following prioritisation of other eligible groups and subject to vaccine supply

3. Organisations should vaccinate all frontline health and social care workers, in order to meet their responsibility to protect their staff and patients and ensure the overall safe running of services.

4. The list above is not exhaustive, and the healthcare professional should apply clinical judgement to take into account the risk of flu exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from flu itself.

5. Healthcare practitioners should refer to the influenza chapter in ‘Immunisation against infectious disease’ (the “Green Book”) for further detail about clinical risk groups advised to receive flu immunisation and for full details on advice concerning contraindications and precautions for the flu vaccines. This can be found at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

## Appendix B: Summary table of which influenza vaccines to offer

| Eligible group | Type of flu vaccine |
|---|---|
| **At risk children aged from 6 months to less than 2 years** | Offer **QIVe.**<br><br>LAIV and QIVc are not licenced for children under 2 years of age. |
| **At risk children aged 2 to under 18 years** | Offer **LAIV**<br><br>If LAIV is contraindicated or otherwise unsuitable offer:<br>• **QIVe** to children less than 9 years of age.<br>• **QIVc** should ideally be offered to children aged 9 years and over who access the vaccine through general practice. Where QIVc vaccine is unavailable, GPs should offer QIVe.<br>• It is acceptable to offer only **QIVe** to the small number of children contraindicated to receive LAIV aged 9 years and over who are vaccinated in a school setting. |
| **Aged 2 and 3 years on 31 August 2020**<br><br>**All primary school aged children and those in Year 7 (aged 4 to 11 on 31 August 2020)** | Offer **LAIV**<br><br>If child is in a clinical risk group and is contraindicated to LAIV (or it is otherwise unsuitable) offer inactivated influenza vaccine (see above).<br><br>For children not in at risk groups, this year if a parent refuses LAIV in some areas an alternative QIVe or QIVc vaccine may be offered to them where possible. |
| **At risk adults (aged 18 to 64), including pregnant women** | Offer:<br>• QIVc<br>• QIVe (as an alternative to QIVc) |
| **Those aged 65 years and over** | Offer:<br>• **aTIV*** should be offered as it is considered to be more effective than standard dose non-adjuvanted trivalent and egg-based quadrivalent influenza vaccines.<br>• **QIVc** is suitable for use in this age group if aTIV is not available.<br><br>* It is recommended that those who become 65 before 31 March 2021 are offered aTIV ‘off-label’. |

## Appendix C : Healthcare worker flu vaccination best practice management checklist

For public assurance via trust boards by December 2020

| A | Committed leadership | Trust self-assessment |
|---|---|---|
| A1 | Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers | |
| A2 | Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers | |
| A3 | Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt | |
| A4 | Agree on a board champion for flu campaign | |
| A5 | All board members receive flu vaccination and publicise this | |
| A6 | Flu team formed with representatives from all directorates, staff groups and trade union representatives | |
| A7 | Flu team to meet regularly from September 2020 | |
| **B** | **Communications plan** | |
| B1 | Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions | |
| B2 | Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper | |
| B3 | Board and senior managers having their vaccinations to be publicised | |
| B4 | Flu vaccination programme and access to vaccination on induction programmes | |
| B5 | Programme to be publicised on screensavers, posters and social media | |
| B6 | Weekly feedback on percentage uptake for directorates, teams and professional groups | |
| **C** | **Flexible accessibility** | |
| C1 | Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered | |
| C2 | Schedule for easy access drop in clinics agreed | |
| C3 | Schedule for 24 hour mobile vaccinations to be agreed | |

| D | Incentives | |
|---|---|---|
| D1 | Board to agree on incentives and how to publicise this | |
| D2 | Success to be celebrated weekly | |

## Appendix D: Children's flu vaccination programme

1. A recommendation to extend flu vaccination to children was made in 2012 by JCVI to provide both individual protection to the children themselves and reduce transmission across all age groups[2]. Implementation of the programme began in 2013 with pre-school children offered vaccination through GP practices and pilots for school aged children. In 2015/16 the programme began nationally in a phased roll-out starting with the youngest school-aged children first and was fully implemented for all primary school aged children in 2019/20.
2. This year as part of our wider planning for winter, in case we see flu and COVID-19 both circulating at the same time, PHE have secured additional vaccine to enable the programme to be extended into Year 7 in secondary schools in 2020/21. Although it is the first time Year 7 pupils will be offered the vaccine nationally, these children will have been offered the flu vaccine when they were in primary school so both they and their parents will be familiar with the programme.
3. In 2020/21 children will be offered vaccination in general practice or through a schools provider as follows:
    - all those aged two and three years old on 31 August 2020 (date of birth on or after 1 September 2016 and on or before 31 August 2018) will be offered vaccine in general practice.
    - all primary school children and Year 7 in secondary school (date of birth on or after 1 September 2008 and on or before 31 August 2016) will be offered through a school age immunisation service[3]
4. Research into the first three years of the childhood programme compared the differences between pilot areas, where the entire primary school age cohort was offered vaccination, to non-pilot areas. These include reductions in: GP consultations for influenza-like illness, swab positivity in primary care, laboratory confirmed hospitalisations and percentage of respiratory emergency department attendances[4].
5. At risk children who are eligible for flu vaccination via the school-based programme because of their age will be offered immunisation at school. However, these children are also eligible to receive vaccination in general practice if the school session is late in the season, parents prefer it, or they missed the session at school. GP practices should invite

[2] Joint committee on Vaccination and Immunisation. Statement on the annual influenza vaccination programme – extension of the programme to children. JCVI (2012). 25 July 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/224775/JCVI-statement-on-the-annual-influenza-vaccination-programme-25-July-2012.pdf

[3] Some children might be outside of these date ranges (e.g. if a child has been accelerated or held back a year). It is acceptable to offer and deliver immunisations to these children with their class peers.

[4] Pebody, R. et al. 21 June 2018. Uptake and impact of vaccinating primary school-age children against influenza: experiences of a live attenuated influenza vaccine programme, England, 2015/16. Eurosurveillance. Volume 23, Issue 25. www.eurosurveillance.org/content/10.2807/1560-7917.ES.2018.23.25.1700496

children in at-risk groups for vaccination, so that parents understand they have the option of taking up the offer in general practice.

6. Children in at risk groups for whom LAIV is contraindicated or unsuitable will be offered inactivated influenza vaccine.
7. As in previous years LAIV will be the vaccine offered to the routine age cohorts for the childhood flu vaccination programme as this is the most effective vaccine for this programme. However for 2020/21, consideration is being made to offer an injectable vaccine to those children whose parents object to the porcine gelatine in LAIV, to provide additional resilience against flu in what could be a challenging year. If the parent of a child eligible for the routine childhood immunisation programme refuses LAIV (and they understand that it is the most effective product) and they request an alternative vaccine, this will be offered to them where possible. Providers of childrens vaccination services will receive further instruction on the offering of this service, including vaccine supply arrangements, in due course.

8. Arrangements should be made to ensure that children who missed out on vaccination during the school session are recalled and offered subsequent opportunities to attend. Precise arrangements for achieving this are for local determination. Children of primary school age who are home educated should also be offered vaccination.  Local NHS England/Improvement Public Health Commissioning teams should be consulted for details about local arrangements. Contact details can be found at: www.england.nhs.uk/about/regional-area-teams/

## Appendix E: Vaccine ordering for children's programme

1. The live attenudated influenza vaccine (LAIV) and the egg-grown Quadrivalent Influenza Vaccine (QIVe) are procured and supplied by Public Health England (PHE). For full details of the arrangements on which vaccines to use for children in risk groups who are unable to receive LAIV due to age or contraindications see www.england.nhs.uk/wp-content/uploads/2019/12/NHS-England-JCVI-advce-and-NHS-reimbursement-flu-vaccine-2020-21.pdf. Centrally supplied children's vaccines can be ordered through the ImmForm website: https://portal.immform.phe.gov.uk.

2. PHE ask that timing of vaccine availability is taken into account when earlier vaccination sessions are being arranged, to reduce the risk of disruption to planned activity. Vaccine availability will not be finalised until late summer. The latest and most accurate information on centrally supplied flu vaccines for the children's programme is available on the ImmForm news page.

3. As in previous years, ordering controls will be in place for Fluenz® Tetra in 2020/21 to enable PHE to manage vaccine availability and demand appropriately across the programme. The latest information on ordering controls and other ordering advice for PHE supplied flu vaccines is featured on the ImmForm news page both prior to and during the flu vaccination period. Information will also be featured in Vaccine Update www.gov.uk/government/collections/vaccine-update and disseminated via the National Immunisation Network as appropriate. It is strongly advised that all parties involved in the provision of flu vaccines to children ensure they remain up to date with this information.

## Appendix F: General practice system supplier searches for the 2020 to 2021 flu programme

1. Achieving the influenza vaccine uptake ambitions are a high priority within public health policy every year. In the current context of COVID-19, improving uptake and reducing the impact of flu on the wider health and social care system this priority cannot be understated in 2020/21.

2. GP practices are reminded that the Directed Enhanced Service requires that a proactive call and recall system is developed to contact all at-risk patients through mechanisms such as by letter, e-mail, phone call, or text. Any automated call and recall list should be subject to clinical review. Template letters for practices to use will be available at www.gov.uk/government/collections/annual-flu-programme nearer the time. Practices should also operate a proactive call system for patients not considered at-risk.

3. Public Health England (PHE) commission the PRIMIS team to provide the SNOMED CT code specifications to the general practice system suppliers. Your general practice system suppliers will then provide system searches using these codes to enable vaccine uptake monitoring.

4. It is essential that the general practice system searches are used for vaccine uptake monitoring and NOT amended in any way by business support teams locally. This standard must be implemented to ensure accurate general practice system searches.

5. This approach will enable practices and support the collection of high quality, robust and timely data on vaccine uptake throughout the delivery of the programme. This will also support GP practices and other providers to act to address issues relating to uptake.

6. Each year Public Health England (PHE) are required to collect data to monitor uptake and coverage of the seasonal flu vaccination programme. This is done via two Seasonal Influenza Vaccine Uptake Surveys (approved by the Data Coordination Board, NHS Digital) with data obtained via automated data returns from general practice system suppliers on behalf of GP practices.

7. GP practices should also note that upon receipt of notification of vaccinations given by another provider e.g. pharmacist/midwife, the vaccination should be recorded in the patients' electronic GP practice record in a timely manner. Any data extraction/uploads will only include patients vaccinated outside the GP practice if the information has been returned and appropriately recorded in the patients' GP practice record using the specified codes.

8. If you feel there are additional training requirements to carry out this approach arising from:

   - practice staff turnover, new staff;
   - refresher training; and/or
   - new system functionality;

   then you are advised to discuss these with your CCG who have a responsibility for training within the overarching general practice IT operating framework.

9. The above is separate to the CQRS payment system, therefore your normal payment mechanisms should be used to claim for vaccines given by the GP practice.

# Appendix G: Data collection

## Introduction

1. As in previous years, data will be collected on the uptake of the vaccination. Currently, it is intended that these data collections will follow established processes. Flu vaccine uptake data collections will be managed using the ImmForm website https://portal.immform.phe.gov.uk. PHE coordinates the data collection and will issue details of the collection requirements and guidance on the data collection process. This guidance and flu vaccine uptake data will be available at: www.gov.uk/government/collections/vaccine-uptake

2. In addition to the established ImmForm data collection, further work is currently being undertaken by Public Health England, NHSx, NHS Digital and NHS England to improve the coverage and timeliness of these data collections as well as reducing the burden from data collections. As and when this further work matures, further information will be provided and may modify the data collection processes outlined below.

3. Queries concerning data collection content or process should be emailed to influenza@phe.gov.uk. Queries concerning ImmForm login details and passwords should be emailed to helpdesk@immform.org.uk.

## Reducing the burden from data collections

4. Considerable efforts have been made to reduce the burden of data collections on GP practices by increasing the number of automated returns that are extracted directly from general practicesystem suppliers. Over 95% of GP practices benefited from using automated IT data returns for flu vaccine uptake for the final 2019/20 survey. GP practices that are not able to submit automated returns should discuss their arrangements with their general practice system supplier. If automated returns fail for the monthly data collection GP practices will be required to submit the mandatory data manually on to ImmForm to meet contractual obligations.

## Data collections for 2020 to 2021

5. Monthly data collections will take place over five months during the 2020/21 flu immunisation programme. Subject to the approval from the Data Coordination Board the first data collection will be for vaccines administered by the end of October 2020 (data collected in November 2020), with the subsequent collections monthly thereafter, and with the final data collection for all vaccines administered by the end of February 2021 (final data collected in March 2021).

6. Data will be collected and published monthly at national level, clinical commissioning group (CCG) level, local authority (LA) level, NHS Sustainable Transformation Partnerships and by 2019 NHS England local team level.

7. During the data collection period, those working in the NHS with relevant access rights are able, through the ImmForm website, to:
   - see their uptake by eligible groups
   - compare themselves with other anonymous general practices or areas
   - validate the data on point of entry and correct any errors before data submission
   - view data and export data into Excel, for further analysis
   - make use of automated data upload methods (depending on the general practices system supplier used at GP practices)
   - access previous years' data to compare with the current performance

   These tools can be used to facilitate the local and regional management of the flu vaccination programme.

## Monitoring on a weekly basis

8. Weekly uptake data will be collected from a group of GP practices that have fully automated extract and upload facilities provided by their general practice system suppliers. These data will be published in the PHE weekly flu report available throughout the flu season at: www.gov.uk/government/statistics/weekly-national-flu-reports.

9. During the data collection period, those working in the NHS with relevant access rights are able, through the ImmForm website to view this data as per the monthly collections.

## Appendix H: Antiviral medicines

1. Antiviral medicines (AVMs) have an important role to play in managing symptoms of flu for specified groups of patients, especially for people who may not get vaccinated against seasonal flu.

2. AVMs can only be prescribed by GPs and non-medical prescribers in primary care during the flu season, once a Central Alerting System (CAS) Alert has been cascaded to GP practices and community pharmacies by the Chief Medical Officer (CMO) and Chief Pharmaceutical Officer authorising the prescribing and supply of antiviral medicines AVMs at NHS expense, informed by surveillance data from Public Health England (PHE), that indicates that flu activity has risen above baseline levels, across a number of indicators.

3. Antiviral medicines may be prescribed for patients in “clinical at-risk groups” as well as individuals who are at risk of severe illness and/or complications from influenza if not treated.

4. Information on clinical at risk groups and patients eligible for treatment in primary care at NHS expense with either oseltamivir or zanamivir is available from: www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents

5. Once PHE informs DHSC that the level of seasonal flu activity is below threshold levels at the end of the flu season, another CMO CAS Alert is cascaded to stop the prescribing and supply of AVMs.

6. The statutory prescribing restrictions that apply to primary care do not apply in secondary care. Hospital clinicians can continue to prescribe antiviral medicines for patients whose illness is confirmed or clinically suspected to be due to influenza, in accordance with PHE guidance for the treatment of complicated influenza.

7. The Department of Health and Social Care works with manufacturers of antiviral medicines from summer and throughout the flu season to monitor supplies of antiviral medicines to ensure adequate stocks are available in the supply chain to meet demand.