

## Briefing Note: NHS England - phase three of the response to Covid-19

The NHS in England has now officially entered phase three of its response to Covid-19.<sup>1</sup> This briefing provides an overview of what this new phase means in practice.

### Introduction: why phase three and when

Phase three came into effect on 1<sup>st</sup> August, as announced on 31<sup>st</sup> July by Sir Simon Stevens and Amanda Pritchard [in a letter to ICSs and STPs, NHS trusts, CCGs and NHS bodies](#) throughout the country. Alongside the letter, [technical guidance](#) has also been published to provide greater detail on what steps NHS bodies need to take to:

- protect those at greatest risk of Covid-19
- restore services inclusively and accelerate targeted prevention programmes
- improve leadership and accountability
- enhance the collection and use of data
- collaboratively plan for the future of health and care services.

The announcement of phase three follows several developments in the response to the pandemic, including a significant drop in inpatient Covid-19 numbers - from 19,000 per day at its peak to approximately 900 per day currently – and the UK Government’s decision to downgrade its alert level. As a result of these factors, the Government agreed to lower NHS England’s own Covid-19 alert from level four – a nationally directed response – to level three – one led at a regional level.

NHS England have set out a series of expectations regarding the resumption and rapid recovery of non-Covid care paused during the emergence and peak of the pandemic. This includes a range of specific and highly ambitious targets to be met from August onwards, with several extending into 2021.

These targets represent an important shift in focus, with NHS England now intending to maximise the provision of non-Covid care in the coming months, in principle to help clear the significant backlog in elective care, screenings, and diagnosis built up since March.

In essence, national leaders want the NHS to provide as much non-Covid-19 care as is absolutely possible in the remainder of 2020, before the onset of winter pressures or further peaks in Covid-19. This undoubtedly presents major challenges for doctors and raises numerous concerns for the BMA.

### The changes: at a glance

Phase three brings a range of new aspirations that trusts, CCGs, and health systems are expected to meet from August onwards. As stated in NHS England’s letter, these are focused around three specific priorities:

- A. Accelerating the return of near-normal levels of non-Covid-19 care
- B. Preparation for winter pressures, with vigilance for potential spikes in Covid-19 cases both regionally and nationally

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<sup>1</sup> Phase one – January to April – represented the initial, acute care-focused response to the pandemic; and phase two – May to July – saw the beginning of a reduction in acute Covid-19 pressures.

### C. Achieving the above while taking account of lessons learned during the response to Covid-19

In practice, these priorities – and especially the return to ‘near-normal’ levels of non-Covid-19 care – will require dramatic increases in service provision over the next three months and beyond.

Various targets have been published for each of the three priorities, setting out rapid and profoundly ambitious trajectories for restoring services – which may, in some cases, see abrupt changes in workload for NHS staff.

Phase three will also see a significant, though not unprecedented, increase in the role and responsibilities of local health and care systems – as part of the shift from the national to regional response to the pandemic. This raises its own potential issues, not least due to ongoing concerns regarding the accountability of ICSs and STPs to the public and to frontline clinicians.

Regarding funding arrangements, phase three brings no immediate changes. Nationally set block contracts for NHS trusts and commissioners will remain for the immediate future. However, a revised financial framework is intended to be in place by the end of 2020/21 – details of which are yet to be confirmed following the Comprehensive Spending Review.

### Targets and goals: new and old

As part of phase three, from August onwards the NHS is expected to begin to deliver on a range of new targets and goals, under the three overarching priorities. These cover a range of issues and specific areas of care, but all broadly mean delivering non-Covid-19 care at rapidly accelerating rates.

A full list of these targets is available in the letter itself, [here](#), however, they notably include:

### Restoring cancer services

Restoring the full operation of all cancer services is a major priority for NHS England. In order to deliver this, they have advised health and care systems that they should commission their local [Cancer Alliances](#) to quickly produce delivery plans for cancer care between September 2020 and March 2021.

These plans are to cover how the following will be met:

- reducing unmet need and tackling health inequalities
- restoring the number of patients presenting and being appropriately referred with suspected cancer to pre-Covid-19 levels
- managing the immediate growth in demand for cancer diagnosis and/or treatment, by:
  - ensuring enough diagnostic capacity is available in Covid-19-secure environments, including via the use of independent sector facilities, as well as the development of RDCs ([Rapid Diagnostic Centres](#)) and general community-based diagnostic Hubs
  - increasing endoscopy provision to normal levels and, where appropriate, use CT colonography as an alternative to colonoscopy
  - expanding surgical hub capacity
  - supporting groups with potentially unequal access to treatment
  - restarting all cancer screening programmes in full
- restoring waiting times for diagnostics and/or treatment to normal levels.

## The BMA view

The delays in cancer diagnosis and screenings caused by Covid-19 are significant and undoubtedly pose both a major challenge to cancer services and a significant risk to patient outcomes. The BMA has [estimated](#) that there were nearly 300,000 fewer urgent cancer referrals across April, May and June 2020 than would normally be expected. We therefore welcome the priority NHS England has placed on cancer care.

However, the goals set are highly ambitious and will place severe strain on the cancer care workforce and on available capacity.

## Maximising elective activity

NHS England are also prioritising delivering the maximum elective activity possible between August and winter, using all NHS and independent sector capacity available, and with the explicit expectation that trusts are to restore their capacity to the following levels:

- in August, at least 70 percent of their previous year's elective activity for both overnight and outpatient/day cases – rising to 80 percent in September and 90 percent in October
- at least 90 percent of their previous year's levels of MRI/CT endoscopy procedures – reaching 100 percent by October
- from August, 90 percent of their previous year's activity for first outpatient attendances and follow-ups (either face-to-face or virtually, though clinicians are advised to avoid the former whenever appropriate), rising to 100 percent from September.

NHS England have also announced several additional steps and instructions intended to support providers to achieve these targets, including:

- the continuation of national contracting of independent hospital capacity through to March 2021 – with use of this space monitored closely by health and care systems
- the extension of current financial arrangements for trusts and CCGs – including block contracts – through August and September 2020, ahead of the introduction of a new financial framework in late 2020/21
- block contracts will flex according to delivery against the set targets – further detail is pending on this point, but it appears that failure to deliver against the targets may result in reduced payments
- clinically urgent patients will continue to be prioritised, but with next priority given to those patients who have been waiting the longest
- trusts and GP practices should collaboratively communicate with patients who have had treatments disrupted by Covid-19, including when and how they will be treated
- trusts are now instructed to follow new NICE guidelines which remove the previous requirement for patients to isolate for 14 days prior to admission or treatment
- trusts are to ensure that their e-referral services are fully open to referrals from primary care – and that where possible patients are treated without onward referrals
- give patients greater control over outpatient follow-up care, using a PIFU (patient-initiated follow-up) model across major outpatient specialties. Under the PIFU approach, patients can be given the guidance and responsibility to decide when they need follow up appointments, based on their symptoms.

## The BMA view

The proposed increases in activity - by ten percent in September and again in October - will be immensely challenging to deliver. We are sceptical that such dramatic increases in provision will be possible without the cutting of corners or impinging upon staff health and wellbeing, given that those staff must also continue to meet the demands of Covid-19 whilst maintaining both social distancing and Covid-19 PPE precautions.

Moreover, if funding – via block contract – is dependent on performance against these seemingly arbitrary targets, it risks further punishing already struggling providers for failing to meet them. NHS England needs to be prepared for the event that providers miss their targets and to ensure that proper support, including funding, is available and provided to those that do – for the benefit of organisations, staff, and their patients.

NHS England also needs to recognise that its specific targets for service recovery and wider goals around waiting times and patient priority will put a range of services under intense pressure. For example, waiting lists are likely to include a considerable number of mental health referrals from GPs, considering the length of time it takes from primary referral to secondary care treatment. This means that specific services may also need targeted investment and support as phase three progresses – which is especially important to historically underfunded services like mental health.

Regarding the contracting of private sector capacity, we recognise why contracts were drawn up during Covid-19, given the concern that NHS beds may be insufficient to meet demand. However, the perceived need for these arrangements has exposed the significant lack of investment into the NHS over many years.

These contracts have also been agreed with an alarming lack of transparency. We still do not know their total cost, or how much private sector capacity has been used during the pandemic. BMA members have, for example, reported private sector facilities under contract standing empty during the pandemic. The opaque nature of these arrangements has been further clouded by NHS England's decision to terminate its block contracts with all private hospitals in London and a number of other areas, despite its clear statement in the phase three announcement regarding their continuation.<sup>2</sup>

There are concerns that the changes in guidance around patient self-isolation prior to treatment are lacking in consistency. In the advice given, an isolation period of three days is advised for low risk pathways, but patients at risk of severe consequence from Covid-19 infection are advised that they should self-isolate for 14 days. We are following up with NHSE/I on this variation.

In respect of the PIFU model, we believe that any such approach must be flexible and used carefully, as it will not be suitable for all patients. NHS England should also take steps to highlight the risks and problems experienced where these models have been used, as a resource for teams considering its further adoption and as a means of sharing best practice. Continuous and thorough analysis of PIFU in practice is also necessary, to ensure that, for example, patients do not over-use or under-use the appointments. Lastly, this change will need to be properly accounted for in future funding arrangements, given the change in Trust activity.

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<sup>2</sup> The BMA report [The role of private outsourcing in the COVID-19 response](#) offers further analysis of the role of private providers in the response to the pandemic thus far.

However, elements of the support and guidance set out in this section are certainly more positive and several meet specific calls made by the BMA in our lobbying. Setting out that priority will be given first to urgent cases and second to those with the lengthiest wait is important and meets our ask for clear national criteria, to help avoid a postcode lottery. Our work on the primary-secondary interface has also been clear that better communication and co-operation between trusts and GPs is vital, so it is positive to see our calls reflected in NHS England's guidance.

Virtual consultations have a role to play, alongside face-to-face appointments. However, they will need to be supported with proper investment in IT and technology, so that doctors have what they need to properly and efficiently carry out remote consultations.

## Primary and community care

NHS England have set out a range of expectations for GP practices, PCNs (Primary Care Networks), community services and CCGs in order to restore service delivery in primary and community care. These include:

- GP and community services should restore activity to usual levels where clinically appropriate – while also proactively reaching out to vulnerable patients
- GP practices and PCNs are to make rapid progress on clearing backlogs for childhood immunisation and cervical screenings
- CCGs should work with practices to increase the range of services available for self-referral, to free up clinical time
- community health teams should fully resume home visiting for vulnerable patients
- from 1<sup>st</sup> September, hospitals and community providers should completely embed the 'discharge to assess' model – which looks to discharge patients who do not require an acute hospital bed, but may need care services, to their home or to a community facility where assessment for their longer-term care and support needs is undertaken - with funding available to keep patients out of hospital
- GPs are to use capacity released by the modification of QOF requirements for 2020/21 to develop priority lists for preventative support and long-term condition management
- all GP practices must offer face-to-face appointments as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate.

## The BMA view

GPs and the whole primary care workforce have played a vital role in the response to Covid-19. While facing immense demand, they have continued to act as a first port of call for a huge number of patients and, like doctors in all services, have innovated to provide care however and whenever needed - including the widespread use of remote consultations. In the recent [Trust GPs to Lead report](#), the BMA has set out a range of principles and solutions that will enable GPs and practices to manage the ongoing demands of responding to COVID-19.

Elements of the phase three announcement absolutely reflect this and show the successful lobbying carried out on behalf of GPs by the BMA - such as the requirement for CCGs to increase the range of services available for self-referral in order to free up clinical time. The recognition of the importance of in-person appointments within general practice, alongside the use of remote consultations is also a positive step.

However, it is important that NHS England acknowledge the ongoing pressure on primary care services and that the need to deliver services in as safe an environment as possible. With the extra

requirements around cleaning and social distancing, a return to 'normal' levels of provision is not a reasonable expectation.

## Mental health services

Phase three includes specific expectations and steps around the expansion and improvement of mental health services and support for those with learning disabilities. NHS England's technical guidance covers these points in substantial detail, however, in brief, they include:

- increased investment in mental health services by CCGs - in line with the Mental Health Investment Standard
- continuing work towards eliminating mental health dormitory wards by utilising £250 million of earmarked capital funding in 2020/21, with a further sum available next year
- the full resumption of IAPT services – with national support to grow services and hire additional trainees, as NHS England see IAPT services at the forefront of phase three
- retention of 24-hour crisis helplines introduced during the pandemic
- proactive reviews should be carried out of all patients on mental health teams' caseloads
- clear advertising of access to mental health and support services
- GP practices should ensure patients with learning disabilities are on their registers and have access to screenings and vaccinations
- systems are also required to focus on advancing equalities of access, experience and outcomes for the BAME and LGBT+ communities, as well as for older people, and young people with neurological development disorders.

## The BMA view

The BMA has been advocating for increased mental health funding for some time, so we welcome the reaffirmed expectation for CCGs to increase funding in line with the Mental Health Investment Standard.

NHS England has recognised the growing demand for mental health care generated during the pandemic and the consequent need both for IAPT services to be clearly signposted and for barriers to them to be reduced as much as possible. Whilst this recognition, taken with the reaffirmation of upholding the MHIS, is welcome, it is, after all, still only a reiteration of previous promises. We have asked for CCGs to receive dedicated funding in light of the anticipated increased demand and have called for mental health funding to be doubled over the course of the NHS Long Term Plan.

The full resumption of IAPT is welcome too, and the BMA has called for all access standards, including IAPT, to be resourced adequately to allow for efficient restoration of services.

We will closely monitor progress in both funding and access.

## Preparing for winter and/or a second wave

NHS England has set out a series of expectations for NHS bodies to meet in preparation for winter and a potential further wave of Covid-19, in recognition of the impact both will have on the restoration of non-Covid-19 care. These include:

- follow PHE guidance, DHSC policies, and best practice – including on staff testing
- continue to minimise infection risk by securing 'Covid-19-free zones', ensuring strict hygiene adherence, distancing, and the use of face masks

- ensure staff and patients have adequate access to PPE – drawing on DHSC’s sourcing and stockpiling
- sustain current bed and staffing capacity
- deliver a significantly expanded flu vaccination programme
- expand the scope of 111 First, to offer a greater range of support – including low complexity urgent care and the services to which operators can refer patients directly.<sup>3</sup>

#### The BMA view

The coming winter could be one of the worst in the history of the NHS, with the usual pressures compounded by ongoing difficulties posed by the pandemic and the possibility of further waves of Covid-19. Adequately preparing to run this gauntlet while also rapidly and comprehensively restarting non-Covid care is a monumental challenge.

The expansion of the 111 First model could be beneficial in reducing demand on emergency and urgent care services, which we welcome. However, care must be taken that this does not redirect demand to other struggling services and that patients are not sent in circles trying to access care. The success of this model will hinge on there being sufficient clinical capacity within the 111 service to provide effective oversight of advice and triage decisions.

The expectation that GP practices and primary care services should simultaneously deliver ‘normal’ levels of provision alongside a significantly expanded flu vaccination programme - while also strictly adhering to Covid-19-safe guidelines including distancing and cleaning between consultations, for example – requires adequate support from NHSE/I and CCGs.

We are also clear in our view that Covid-19-free zones do not exist in reality, due to asymptomatic transmission. This is a point we have argued in our feedback on Public Health England’s latest infection prevention control guidance, too. It is vitally important that NHS England recognise this and put the proper precautions in place.

If doctors and frontline staff are expected to balance the impending winter with the ongoing crises caused by Covid-19, they absolutely must be given the time, resources, and quality equipment needed to do so properly. This includes an adequate supply of high quality, appropriately fitted PPE reaching the right services at the right times. It is crucial that staff have access to PPE that is appropriate for the environment in which they are working and that any changes to PPE requirements are based on nationally agreed standards, developed in consultation with staff representatives.

The recognition that both staff and patients need access to adequate PPE is welcome in this respect. However, frontline clinicians may find it difficult to place their trust in the PPE sourcing and stockpiling systems that have already failed them.

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<sup>3</sup> Under the 111 First model, patients are asked to contact NHS 111 prior to attending an emergency department, call handlers will then either book a time slot for them at an emergency department or make them an appointment at the most appropriate service – however, all patients who require a blue light response will still receive one.



## Learning lessons from Covid-19

NHS England has set out a number of steps that it expects providers, commissioners, and systems to undertake, in conjunction with [We are the NHS: People Plan 2020/21](#), to take account of the lessons learned during Covid-19 including:

- a commitment to keep all staff safe, healthy and well
- offering staff flexible working
- delivering new ways of working and delivering care
- protecting and growing the existing workforce to meet demand.

### The BMA view

Our own work on the learning we need to take from Covid-19 is ongoing, but we have been clear throughout that the need to value and protect staff must be at heart of any lessons learnt from the pandemic. The BMA has stressed this to NHS England, DHSC and stakeholders throughout the country.

Likewise, we have been clear that allowing and offering flexible working to those staff has been a clear benefit of the new ways of working brought on by the pandemic, and one that should be retained. We therefore welcome their inclusion in NHS England's announcement of phase three and the 2020/21 People Plan.

The People Plan highlights several areas for improvement that the BMA has long been calling for, not least the focus on wellbeing, research and education, and flexible working. Though we continue to feel that detailed plans for how these ambitions will result in real, meaningful change for staff are urgently needed. [The BMA's comprehensive analysis of the People Plan is available here.](#)

## Health inequalities and prevention

Tackling health inequalities and improving prevention are primary goals for NHS England in phase three. As part of this work, the health service is expected to:

- ensure that the recovery from the pandemic is planned to inclusively support those in greatest need
- protect the most vulnerable from Covid-19 – through enhanced analysis of its spread and thorough community engagement
- develop digitally-enabled care pathways in such a way as to increase inclusion, while carrying out analysis of who is and who is not using these services, and why
- test the impact of new care pathways on health inequalities – starting with 111 First, total triage in general practice, digitally-enabled mental health care, and virtual outpatients
- accelerate preventative programmes, including flu vaccinations, obesity reduction, diabetes prevention, and health checks for those with learning disabilities
- have a named executive board member responsible for tackling inequalities in place at every NHS organisation by the end of September
- ensure data sets are thorough, comprehensive, and relevant – to make their use as effective as possible. This includes an explicit focus on using patient ethnicity data to support general practice to prioritise those groups at significant risk of Covid-19



## The BMA View

We welcome the clear instruction within the phase three guidance for protection and support for the vulnerable groups – including those most at risk of Covid-19. Likewise, we welcome the clear focus on tackling inequalities and the requirement for a named executive board member responsible for this for every NHS organisation – something the BMA has called for consistently, including in our *Caring, Supportive, Collaborative* project and as one of our [Ten principles for restarting non-Covid care](#).

Thorough analysis of who is and who is not using digital services is also vital, particularly in ensuring that the drive on providing remote care does not further disadvantage already vulnerable groups.

## Recovery and health and care systems

Local health and care systems will play a pivotal role in phase three. Working collaboratively with their local member organisations, ICSs (Integrated Care Systems) and STPs (Sustainability and Transformation Partnerships) are required to have submitted final plans to deliver the key actions set out by NHS England by 21<sup>st</sup> September.

These plans are also expected to include:

- the agreement of new collaborative leadership arrangements – designed to allow rapid decision making to take place at system level
- the establishment and/or strengthening of Partnership Boards within the system, to support member organisations to make key decisions collaboratively and to ensure transparency
- the streamlining of commissioning processes within individual ICSs and STPs - in line with the Long Term Plan's goal of typically having a single CCG per system
- a plan for creating and instituting a system-wide shared care record

Systems will also be expected to manage elective waiting lists and operational performance alongside their providers – with a view to ensuring patient access and optimum use of resources, including the private capacity currently block booked by the NHS.

Systems are also required to produce their own local plans for their workforce planning and transformation (so-called local people plans) – further securing their position and responsibilities.

## The BMA view

The BMA has longstanding concerns regarding the transparency and accountability of ICS and STPs, and about their engagement with frontline staff. We are, therefore, wary that those systems are set to take on such significant responsibilities as we progress through phase three.

NHS England and each ICS and STP must ensure that frontline clinicians are meaningfully involved in the planning undertaken during phase three – and that any such planning reflects first and foremost the needs of patients and staff, not nationally-set targets. The BMA will seek to influence these plans and will, when possible, carry out individual analysis of them.

We are also concerned that future and impending mergers of CCGs are highlighted prominently in the letter. The BMA is adamant that the pandemic and the response to it cannot be used to drive forward major changes in system architecture without proper consultation and engagement. CCG mergers are by no means a foregone conclusion and depend on local decisions by clinicians – they

should not be pushed through while staff are desperately managing the pandemic or, as of August, the rebuilding of service provision.<sup>4</sup>

However, we do recognise the role that ICSs and STPs have to play in co-ordinating responses to the pandemic at a system-wide level and in fostering wider change within local NHS organisations. On this basis, we welcome the explicit expectation for each system to plan for the creation and use of a local shared care record. The BMA has consistently called for improvements in record sharing between primary and secondary care to break down both boundaries between NHS organisations and barriers to smooth, uninterrupted patient care.

## Conclusion

While NHS England's goals are understandable, given the vast and ever-growing waiting lists that Covid-19 has caused to pile up across the country, they are highly ambitious and risk outstripping the capacity of the NHS and its committed, but overstretched workforce.

Doctors and frontline NHS workers have for months dedicated their lives to coping with the pressures of Covid-19, providing care wherever and however it was needed. In many areas much of this work continues. So, to push for such a rapid and dramatic increase in non-Covid-19 provision requires not only a major shift in resources and working patterns, it will place additional pressure on staff who, quite frankly, are exhausted. This is not a simple task and it is vital that NHS England recognises this, not least given its rhetoric around the need to support its workforce, both physically and mentally.

Equally, it is highly possible, if not likely, that these goals will not and cannot be met by the NHS in its current state – regardless of the availability of private sector capacity and the redeployment of staff. Returning service levels to their normal standard amid an ongoing pandemic and with extra infection control protocols and procedures is an extremely challenging task. NHS England and the government must be realistic about what they can expect to be achieved in such a narrow time frame, not least given the need to prepare for what is likely to be the worst winter on record for the NHS.

Frontline staff have been and will be the lynchpin of every phase of the response to Covid-19, as they will be to the recovery from it. Therefore, decisions must be made not only with their best interests in mind, but also with their explicit and meaningful involvement.

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<sup>4</sup> For more information on CCG mergers, [see the BMA's guidance here](#).