HM TREASURY

Briefing for PM 'Health Plan' meeting

22.03.2020

Background

1. At Friday's 09:15, there was an action for DHSC to produce a 12-week plan to address the health related aspects of CV19. DHSC have structured this as follows:
    1. Resilience
        - NHS (current plan – beds / ventilators / workforce etc)
        - Social Care
        - Supply
    2. Testing
    3. Technology
    4. Social distancing
    5. Shielding

2. We have now seen a draft DHSC plan. Whilst it includes some sense of proposed timings, metrics and milestones, it is still substantially less detailed than you might expect at this point and contains very little information on expected trajectories, stop/go points for specific interventions or a coherent plan – based on supply, demand and interventions – for controlling the health response across the country.

Points to make on the 'plan'

6. This overview shows some progress – welcome initial thinking about metrics, milestones and sequencing. This is substantially more detail than my team have seen so far.
7. But it is still <u>far too light on detail and coherence</u> given we have now had a number of weeks to work through this. We really need:
    - Trajectories for a small number of **indicators/metrics** per priority. Currently, for example, I do not know:

- what you are aiming for on **workforce; ICU capacity or adult social care capacity** – either in total, over time or across regions/local footprints *[note the plan does include overall targets for supply and testing, but no trajectories or sub-national breakdown – so no ability to monitor if we are on plan];*
- what you expect to happen to **NHS and ASC demand and supply in any area of the country**;
- what you think the **impact** of many of the interventions we've signed off this week will be, and what our **clear stop/go decision points** are which will show us if interventions are working and when the next level may be needed.

- A better **decision making process** – across government, the NHS and LG – in line with these trajectories.
- A proper process for assessing the **efficacy of health interventions internationally** and ability to deploy learning at speed – i.e. why are we so far behind comparator countries on testing (see pg3)?
- Better **central coordination** to balance supply and demand across the country.

8. My team are already doing a daily call with NHS/DHSC finance:
   - They have also asked for a daily call with No10 colleagues and DHSC policy side – <u>we should facilitate this.</u>

9. CST attended the Health Committee meeting this morning where this plan was discussed. He requested a number of metrics last night following our call (see Annex) which were not provided – although the plan does commit to measuring some of them. He asked to pass on the following, which aligns with points above and in the following section:

Simon Stevens said that he will not have data on supply and demand (other than for London) for the meeting this afternoon. Regional data on supply and demand won't be available for another week and further breakdowns sometime after that. CST's view is this is unacceptable for three reasons: (1) it's clear without this information government and the NHS doesn't have a coherent plan to shift resources around the countries to hotspots; (2) we've essentially shut down the economy and provided funding to the NHS based on demand modelling, yet we don't have any indication whether our

interventions will be enough to meet future demand (links back to 1 on there not being a coherent plan); and (3) CST thinks NHSE/I must have this data and simply aren't sharing it with Ministers. ***CST strongly recommends that you raise this as a matter of urgency with the Prime Minister this afternoon.***

Wider points to make

A) Operationalising the response

This week, we've agreed (publicly and privately) to **over £6bn NHS/social care spend**. But clear that money alone is not enough.

1. **Central coordination** needs to be better.
    - Already seeing that this is not working properly for PPE supply – c2 weeks supply across the country, but (anecdotally) some trusts saying they have none.
    - In next few weeks this will be particularly critical for addressing workforce gaps – do you plan to move staff? Who's the decision maker?
2. Push to be more inventive on **workforce** (particularly in light of your (CX) annos yesterday)
    - What are next steps on volunteers (proposal here still unclear, particularly weak in ASC)?
    - Given concerns e.g. with 111 and adult social care capacity, can we use furloughed capacity elsewhere in lower skilled roles? (There would be time for basic training pre peak. e.g. 111 training 'normally' takes 4-6 weeks).
    - Are we thinking as inventively as possible about tech/Babylon-like platforms? Can we immediately roll out more widely so self-isolating GPs can still work?
    - DHSC needs to input more to wider govt workforce planning outside strict NHS/ASC parameters – e.g. shielding proposals rely on capacity in the delivery sector to the c4.5m deliveries per day needed. We are not clear these have yet been fully considered.

B) NHS's role in the economy:

3. Many trusts have a critical role in local ecosystems. What are they doing to support their supply chains.

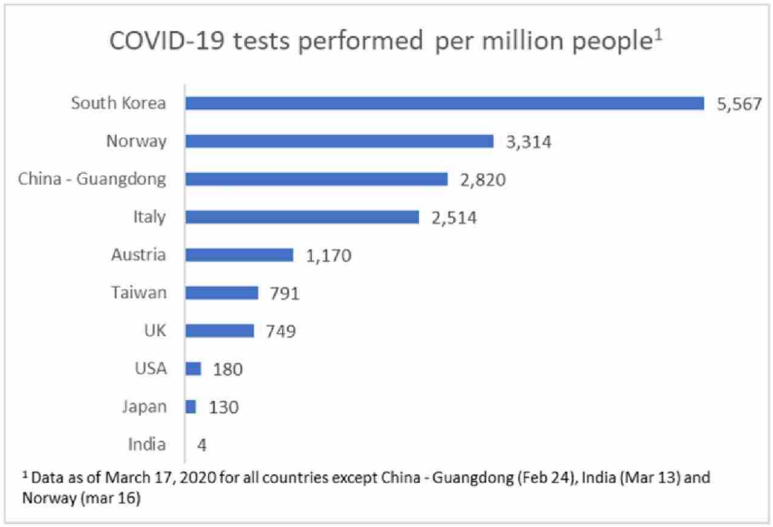
4. NHS overall employs 1.4m people, and trusts are a major local employer – is anything more needed? Will need them to be part of longer-term recovery plan.

C) Markers for the longer-term recovery:

5. Over the last week we have taken exceptional steps, but many of which follow the grain of reforms we have long been pushing for (more workforce flexibility, shorter nursing courses, more NHS focus on discharge).
    - However difficult now, we should not lose sight of potential long-run benefits of this crisis in making the NHS more sustainable and more effective.
    - Want to keep this on the radar throughout and act quickly afterwards to cement.
6. Equally, other measures really must be time limited – e.g. suspension of the means test for ASC discharges, or suspension of most cost improvement work in Trusts.
    - Every such intervention should be clearly time-limited (allbeit with opportunity for extension) with more thought given as to how it will be sunsetted.

Further detail on testing

You asked for more detail on testing. International comparisons show the UK doing relatively poorly, which DHSC think is likely because our policy so far has broadly been to test those in hospital and no others (this is now shifting):



DHSC have not been able to tell us:

i) Why we're (relatively) so low and how Italy, Austria etc are doing so much 'better'

ii) Whether they feel this is an issue, i.e. is there any correlation between testing and 'successful' handling of the virus in health or economic terms (i.e. South Korea and Italy testing a lot but still struggling)

iii) What the testing mix is within these countries (i.e. who's focusing on healthcare workers vs general population etc, who's using antigen tests etc)

iv) How France and Germany are doing.

They have agreed to work with us urgently over the net few days to answer these questions – and **you may want to push the Health Secretary on this as these questions feel fundamental to their testing strategy**.

Updates on funded health commitments (all agreed this week)

Commitment	**Purpose/target if known**	**Cost (committed vs *projected*)**	**Status/HMT clearance**
Capacity (NHS): enhanced discharge	Explicitly to free up at least 15k beds	£1.3bn	Announced 18 March
Capacity (NHS/ASC): LA support – unringfenced but explicitly linked to social care		£1.6bn	Announced 18 March
Capacity (NHS): Block booking of independent sector	Explicitly to increase capacity by c8k beds	*£345m p.m., minimum 3 month commitment*	Cleared 20 March, not yet announced
Capacity (NHS): Postponement of non-	No clear target	*No estimate – knock on*	Announced 17 March

urgent elective operations		*impact on provider bottom lines*	
Capacity (NHS): NHS Financial Framework amendments e.g. move to block contracts, suspension of certain cost improvement work	No clear target	*No estimate – knock on impact on provider bottom lines*	Announced 17 March
Workforce: 1) NHS returners scheme, 2) student nurse transition	No clear target – 1) 'optimistically' 50% returners (25k)	*£300m-£1bn (more likely lower end)*	Announced 19 March
Workforce: amended T&Cs	No clear target	*C£200 p.m.*	Agreed but not yet announced
Workforce: volunteer compensation	No clear target – DHSC hoping for 650-950k volunteers	£860m	Announced 17 March as part of Bill, details not yet announced, cleared 20 March
Supply: Facilitation of purchase of 1,100 ventilators from China via GBS	Understand aim is to purchase 30k, but no formal confirmation of this	$4m	Facilitated 16 March, not public
Supply: purchase of up to 20k ventilator monitors	Aim is to purchase 30k, as all ventilators need a monitor	£130m	Cleared 21 March
Testing: lab tests for key workers	PM aim for 1m tests per week –	£64m	Cleared 19 March, not yet announced

Testing: mass population fund	split or trajectory not yet clear	£100m	Cleared 19 March, not yet announced
Shielding: Medicines delivery service	To support shielding package	C£300m	Cleared 20 March, TBC announcement 22 March
Tech: Drawdown from Fighting Fund for genomic sequencing	No target associated with fund	£5-10m of £30m fund	Cleared 18 March
Upper bound of overall cost estimate = £6.2bn			

Currently working on:

- Support for DHSC to purchase PPE. No asks yet made. Initial proposal (£ms deposit payments to unverified companies in China) raised issues which we have flagged to DHSC (and they agree). Further due diligence currently being done by post in Beijing and formal request likely to be made this evening (Sunday). Appears that these are legitimate companies, but DD ongoing as to whether this PPE will meet required standards.
- Further testing plans. Again, no asks yet made.
- Cash availability. Asks with DHSC.

Annex: Potential metrics

Following our call with you and CST yesterday, CST requested the following metrics from DHSC last night in advance of this morning's committee. They did not provide data, although there is a commitment to measure some of these in the plan documentation.

'Usual'/baseline, current level and proposed trajectory to be delivered by current and/or future interventions to address CV19 health impacts for the following:

- bed capacity (overall and ICU), to include impact of all capacity measures announced so far and phasing plans

- delayed transfers of care, to include impact of enhanced discharge pot and wider LA fund
- social care packages, to include impact of LA fund
- FTEs in work (across docs, nurses, 111, social care and 'other'), to include impact of workforce initiatives announced and volunteer scheme
- Agency rates being paid broken down by clinical and non-clinical staff
- Supply- ventilators/monitors and PPE (procured and operating)
- Number of tests (across each of 4 testing workstreams), trajectories for meeting targets and waiting times for these

This data should be broken down to trust level where necessary in order to identify hotspots and target support.

Annex: Background to ASC and shielding measures

Resilience / social care

- Top ask is that DHSC work with us to provide a comprehensive picture of what we expect to happen to ASC demand and supply in the next three months so we can help NHS/LAs/Providers to prepare.

Background

- £1.3bn provided for NHS to speed discharge. £1.6bn for LAs, o/w ca. £1.2bn for ASC. HMT think that these numbers are right at the upper end so funding unlikely to be issue. We will keep this under review and are working with DHSC/MHCLG on monitoring.
- Now need info on implementation. Two main issues:
  - What do we expect demand to look like for ASC services in the next few months? [There are both push and pull factors here]
  - Do we think we can get enough supply in at short notice to manage the above demand? [Again, would expect some contractions in workforce but potentially an increase in
- These two factors will be essential for devising a credible plan/set of policies for the NHS, LAs and ASC providers. This may involve suspension of certain existing

services and new delivery models – LAs and providers will be looking to us for guidance so need to do this quickly.
- HMT stand ready to help in this area – e.g. we're drawing up an assessment of the potential push/pull factors in workforce measures that we've initiated and will review with DHSC colleagues to take stock of whether we can/should go further in this space.

Shielding

- Top ask on medicine delivery is that DHSC, supported by BEIS/HMT, review whether there will be capacity in the sector to make the ca. 4.5m deliveries per day needed for this.

Background

- On medicine delivery, we have agreed to provide DHSC with ca. £300m for Pharmacies to organise deliveries to vulnerable people. Again, this is likely at the upper end.
- We're leaving it largely up to pharmacies though to work out how they carry this out in practice. There is a risk that there simply isn't enough capacity in the delivery chain for this to be scaled up at very short notice – we're asking for pharmacies to organise ca. 4.5m new deliveries per week across England.