Board of Directors Information Pack

Board of Directors meeting - 8th September 2020

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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 30 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.

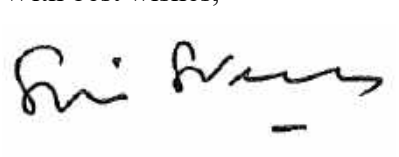
- Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.

- 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.

APPENDIX C - Workforce Race Equality Standard Report 2020/2021

1. **Name of organisation**

   Countess of Chester Hospital NHS Foundation Trust

2. **Date of report**

   Month/Year:
   July 2020

3. **Name and title of Board lead for the Workforce Race Equality Standard**

   Alyson Hall, Executive Director of Human Resources and Organisation Development

4. **Name and contact details of lead manager compiling this report**

   Sophie Hunter
   Equality and Diversity Manager
   sophiehunter@nhs.net

5. **Names of commissioners this report has been sent to**

   Complete as applicable:
   Nikki Griffiths
   Equality and Inclusion Business Partner
   NHS West Cheshire Clinical Commissioning Group
   Nicola.griffiths12@nhs.net
   and
   Jonathan Taylor
   Head of Communications and Engagement
   NHS West Cheshire Clinical Commissioning Group
   jonathan.taylor9@nhs.net

6. **Name and contact details of coordinating commissioner this report has been sent to**

   Nikki Griffiths
   Equality and Inclusion Business Partner
   NHS West Cheshire Clinical Commissioning Group
   Nicola.griffiths12@nhs.net
   and

Jonathan Taylor
Head of Communications and Engagement
NHS West Cheshire Clinical Commissioning Group
jonathan.taylor9@nhs.net

7. Unique URL link on which this report and associated Action Plan will be found

http://www.coch.nhs.uk/corporate-information/equality,-diversity-and-human-rights/workforce-race-equality-standard.aspx

8. This report has been signed off by on behalf of the board on

Name:
Alyson Hall, Executive Director of Human Resources and Organisation Development

Date:
July 2020

9. Any issues of completeness of data

Data range for year five reporting will be based on NHS England WRES data set and the staff electronic system (ESR) at 31st March 2020.

WRES reporting standard requires the publication of visible only BAME staff, this therefore excludes white European and white other. As a result, BAME % in other COCH equality reports will be higher.

10. Any matters relating to reliability of comparisons with previous years

Data for the 2020 WRES runs year end 31st March 2020 and is consistent with the time frame of 2019, which also ran at 31st March 2019.

11. Total number of staff employed within this organisation at the date of the report:

5044

12. Proportion of BAME staff employed within this organisation at the date of the report?

10% overall, 7% visible BAME as per WRES guidance

13. The proportion of total staff who have self-reported their ethnicity

98%

14. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity?

Given the high level of reporting, this was unnecessary.

15. **Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity?**
    n/a

16. **What period does the organisation's workforce data refer to?**
    1st April 2019 to 31st March 2020

17. **Percentage of staff in each salary range of £10k compared with the percentage of staff in the overall workforce. Very Senior Managers (VSM) salaries generally begin at £100k (including executive Board members). Organisations should undertake this calculation separately for non-clinical and for clinical staff.**

    Data for reporting year:
    Ethnicity Summary Pay bandings % BAME

    Non-Clinical Salary Band %

    0-9k = 3.83%
    10-19k = 2.83%
    20-29k = 3.0%
    30-39k = 3.41%
    40-49k = 0.00%
    50-59k = 0.00%
    60-69k = 0.00%
    70-79k = 0.00%
    80-89k = 0.00%
    90-99k = 0.00%
    100k & above = 0.00%

    Clinical Salary Band %

    0-9k = 1.29%
    10-19k = 0.83%
    20-29k = 0.87%
    30-39k = 1.09%
    40-49k = 0.18%
    50-59k = 0.22%
    60-69k = 0.28%
    70-79k = 0.28%
    80-89k = 0.85%
    90-99k = 0.34%
    100k & above = 0.34%

Data for previous year:

Ethnicity Summary Pay bandings % BAME

Non-Clinical Salary Band % 0-9k 1.60%

10-19k = 1.24%
20-29k = 0.36%
30-39k = 0.12%
40-49k = 0.00%
50-59k = 0.00%
60-69k = 0.00%
70-79k = 0.00%
80-89k = 0.00%
90-99k = 0.00%
100k & above = 0.00%

Clinical
Salary Band %

0-9k 2.77%
10-19k = 0.91%
20-29k = 1.63%
30-39k = 0.53%
40-49k = 0.36%
50-59k = 0.17%
60-69k = 0.24%
70-79k = 0.19%
80-89k = 0.96%
90-99k = 0.65%
100k & above = 0.05%

The implications of the data and any additional background explanatory narrative

The salary of BAME staff is represented at high, medium and low parts of the spectrum. The amount of BAME staff earning in the higher paid salary bands are represented in clinical roles compared to non-clinical roles which is reflective of the number of nurses and medics employed by the Trust.

18. Relative likelihood of staff being appointed from shortlisting across all posts.

Data for reporting year:
Shortlisted:
BAME = 25.97%
Starters:
BAME = 7.95%

Data for previous year:
Shortlisted:
BAME = 10.71%
Starters:
BAME = 8.13%

The implications of the data and any additional background explanatory narrative:

From total applicants, those shortlisted who were BAME stood at 25.97% in March 2020 compared to 10.71% on the year earlier. New starts accounted for 7.85% of the total for March 2020 which shows a concerning disparity on previous years.

Further analysis revealed that statistics pulled from TRAC showed incomparable data to previous years, where figures were taken from NHS jobs.

Previously, doctors were recruited via BMJ, with few being recruited via NHS Jobs; however, this division is no longer the situation as all applications come through TRAC.

Out of doctors new hires 27.37% are BAME and 21% are not stated. The figures from TRAC for doctors are better in that just fewer than 3% are not stated. The lack of recorded ethnicity will also impact on the figures, potentially reducing the BAME rate.

TRAC gives only 30 white doctors as staff shortlisted whereas the new starter's gives 98, this is due to the fact that the Junior Doctors on rotational training posts don't go through the same recruitment process and also explains why there is a higher rate for 'Not Stated'.

Nevertheless, in main, the applications and shortlisted both have high rates of BAME, however they only account for 7.85% of new starters therefore a disparity still exists.

The likelihood of shortlisted BAME applicants to be successfully appointed to a position remains higher than the BAME local population. (The BAME population in West Cheshire and Chester according to the Office for National Statistics (ONS) 2011 Census amounts to 5.3% of the total population) but remains of concern given the rise in applications.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

Analysis of ethnicity patterns in recruitment reports from NHS jobs to continue.
Continue to offer focus sessions and virtual networks to BAME groups of staff.

19. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Data for reporting year:
8% of staff entering the disciplinary process identified as visible BAME compared to a 7% BAME visible overall workforce

Data for previous year:
8.2% of staff entering the disciplinary process identified as BAME compared to 6% BAME overall workforce.

The implications of the data and any additional background explanatory narrative:

In the 2020/2021 period there is a data gap of 2%, where staff coming under disciplinary procedures
have not declared their ethnic status. This may slightly affect the accuracy of the equation to gauge the likelihood of staff coming under disciplinary procedures by ethnic grouping. The likelihood of BAME staff going through the disciplinary process has decreased compared to the previous year and is now only slightly more likely to be subject to disciplinary procedures than their white colleagues.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

Provide annual disciplinary by ethnicity profile to Finance & Performance Committee Board as part of the Workforce Equality Assurance Report (WEAR)

20. Relative likelihood of staff accessing non-mandatory training and CPD

Data for reporting year:
BAME = Visible 8 % of BAME staff attended non-mandatory training compared to the visible 7% overall staff.

Data for previous year:
BAME = Visible 4.59% compared to the visible 6% overall staff.

The implications of the data and any additional background explanatory narrative:
Refreshed Training analysis reporting has identified that visible BAME Staff accounted for 8% of total staff who undertook non mandatory and CPD training in 2019/20. BAME staff therefore are slightly more likely than white colleagues to attend non mandatory training.

The Trust will continue to monitor this data in 2020 and promote leadership courses to BAME staff groups.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

Actions will include BAME staff focus groups that include discussion on career progression, promotion of BAME leadership courses from NHS Leadership Academy and a focus on encouraging all staff to access apprenticeships where appropriate including at degree and masters level.

Workforce Race Equality Indicators

21. **KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**

White:
26%

BAME:
27%

Data for previous year

White:
28%

BAME:
27%

The implications of the data and any additional background explanatory narrative:

There has been no change in BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months, this still remains below the % of

the national average for both BAME and white staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months with the benchmark national average median currently standing at 30% BAME and 28% White.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

Continue to promote policies and functions to support staff from bullying and harassment from patients, relatives and the public via communication media including emphasis of the zero tolerance of racism towards BAME employees.

Link to work currently being undertaken as part of the trusts drive to decrease violence towards staff.

22. **KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**

White:
26%

BAME:
32%

Data for previous year

White:
25%

BME:
14%

The implications of the data and any additional background explanatory narrative:

2019 saw a significant increase in the percentage of BAME staff who stated they had experienced harassment, bullying or abuse from staff in the previous 12 months. This rose from 14% to 32% which is higher than the national average of 29%. This is now higher 8% higher than white staff whose national average stands at 29%

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

Continue to encourage an increase in the number of BAME employees participating in the 2020 NHS staff survey.

Utilise BAME networks and focus groups to facilitate discussion on staff perspective on the rise in %

23. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion:

White:
85%

BAME:
68%

Data for previous year

White:
87%

BME:
79%

The implications of the data and any additional background explanatory narrative:

Staff Survey who stated that they believe the Trust to be providing equal opportunities has fallen slightly for white staff but more significantly for BAME staff in 2019 compared to 2018. Only 68% of BAME staff felt that the trust gave equal opportunities compared to 74% national average. The national average for white staff showed little difference at 87%.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

Periodic analysis of data regarding access to leadership and development training by ethnicity.

Publish findings of ethnicity analysis in annual WEAR.

Promote leadership, training and development options to BAME employees via BAME staff virtual networks and a communication strategy on bespoke BAME leadership courses from NHS Leadership Academy.

24. **Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.**

White:
6%

BME:
10%

Data for previous year

White:
9%

BME:
0%

The implications of the data and any additional background explanatory narrative:

Staff who experienced discrimination at work from Manager/team leader or other colleagues rose significantly in BAME staff from 0% (or number too low to publish) in 2018 to 10% in 2019, this compares to a national average of 14% for BAME staff and 6% for white staff.

There was a 3% fall in white staff experiencing discrimination.

It is important to note, that we do not have an indication on if this discrimination was due to race, or another protected characteristic.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

Promote staff support and HR policies on bullying and harassment.

Utilise BAME networks and focus groups to facilitate discussion on staff perspective on the rise in %

25. **Percentage difference between the organisations' Board voting membership and its overall workforce**

White:
100%

BME:
0%

White:
100%

BME:
0%

The implications of the data and any additional background explanatory narrative:

The current ethnicity profile of the Trust Board is 100% White British. The population of BAME residents in Cheshire West and Chester is 5.3%. There is a minimal underrepresentation at Board level of BAME employees due to the Board consisting of fewer than 15 people.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

Promote the Trust's inclusive values regarding future positions at Executive and Non-Executive level where vacancies arise.

Consider building links with local BAME stakeholder groups and organisations to promote BAME application for Exec, Non-exec and Governor Vacancies as they arise.

Consider how the BAME voice can be heard at Executive level.

26. **Are there any other factors or data which should be taken into consideration in assessing progress?** N/A

27. **Organisations should produce a detailed WRES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WRES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at board level, such as EDS2. You are asked to provide a link to your WRES action plan in the space below.**

Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it:
http://www.coch.nhs.uk/corporate-information/equality,-diversity-and-human-rights/workforce-race-equality-standard.aspx

	APPENDIX C - WDES 2020 online questions NHS England
Trust information	
1	Name of organisation *Countess of Chester Hospital NHS Foundation Trust*
2	Date of completing this report *July 2020*
3	Name, job title and e-mail address of the lead compiling this report *Sophie Hunter* *Equality and Diversity Manager* *sophiehunter@nhs.net*
4	Name and e-mail address of the commissioner(s) that the trust' 2020 WDES annual report (metrics data and action plan) will be sent to *Nikki Griffiths* *Equality and Inclusion Business Partner* *NHS West Cheshire Clinical Commissioning Group* *nicola.griffiths12@nhs.net* *and* *Jonathan Taylor* *Head of Communications and Engagement* *NHS West Cheshire Clinical Commissioning Group* *jonathan.taylor9@nhs.net*
5	Unique URL link or existing web page on which the trust' 2020 WDES annual report (metrics data and action plan) will be published *https://www.coch.nhs.uk/corporate-information/equality,-diversity-and-human-rights/workforce-disability-equality-standard.aspx*

6	Date of board meeting at which the trust's 2020 WDES annual report (metrics data and action plan) were, or will be, ratified *Metrics data 21st July 2020* *Action plan 22nd September 2020*
7	Does your trust participate in any programmes or initiatives that are focused on disability equality and inclusion? If yes, please provide examples ***The trust has considered a wide range of initiatives to better engage with disabled staff and carers including:*** • *Virtual Carers group* • *The trust has its own Equality Disability Age and Safeguarding Group consisting of staff, patient representatives and external stakeholders,* • *Promotion of awareness days including disability awareness day, deaf awareness week, carers week,* • *Hosted Manager information training group on neurodiversity* • *Stall holding from local Carers Support Groups* • *Weekly visits for staff and patients from Dementia UK in hospital corridor* • *Online access to work information* • *Flexible working options* • *Carers strategy* • *Occupational Health initiatives including access to a 24 hour counselling service* • *On site Macmillan office that staff can utilise as well as patients* • *Communications initiative to improve equality monitoring (banner etc)* • *Promotion of Equality Champions throughout the trust* • *Work experience and hospital tour day for Young Carers* • *Training sessions on providing reasonable adjustments are given as part of the trusts attendance management training to managers* • *Joined and promoting the Carers UK 'Employers for Carers' Toolkit* • *Training on reasonable adjustments given to managers as part of the attendance management course* • *Question regarding is a staff member needs any reasonable adjustments added as part of the question criteria at local induction for all new staff with their Managers*

Metric 1 – Workforce representation	
8	Did your trust's 2020 data for WDES Metric 1 include any of the following groups of staff? 1) Bank staff, 2) Agency staff, 3) Apprentices 4) Subsidiary group staff. If yes, please detail which staff groups • *Apprentices* • *Bank Staff*
9	Do your staff have access to the ESR self-service portal? *Yes*
10	Please share any examples of actions taken in the last 12 months to increase the disability declaration rates in your trust *Opportunities to self declare are encouraged by Occupational Health and via promotion of the self-service portal.*
Metric 2 - Shortlisting	
11	What level of Disability Confident accreditation does your trust currently hold? (Level 1, 2 or 3) *2*
12	Does your trust use the Guaranteed Interview Scheme? *Yes*
13	Please share any examples of actions that the trust has taken in the past 12 months to improve the recruitment of Disabled staff

	• *Participation in employment schemes in partnership with the job centre* • *Work placement programs* • *Equality and Diversity information stall highlighting ways that the trust supports minority groups in employment via flexible working, staff networks, Occupational Health Resources and apprenticeships at the Trust Career's night* • *Craft session on Equality and Diversity ran with Year 10 students as part of Work Experience Week at the Trust*
Metric 3 - Capability	
14	Did your trust experience any issues with providing the data for Metric 3, which was voluntary last year and mandatory this year? If yes, please provide details *No*
Metric 4 – Harassment, bullying and abuse	
15	Please summarise any actions taken since your trust' 2019 WDES action plan was published to reduce harassment, bullying and abuse in relation to Disabled staff *The trust runs conflict management training to staff* *The Trusts Occupational Health Department contact all staff who report abuse to offer support*
Metric 5 – Career promotion and progression	
16	Does your trust provide any targeted career development opportunities for Disabled staff? *No*

	If yes, or planned, please provide examples
Metric 6 - Presenteeism	
17	Has your trust planned any targeted actions to reduce presenteeism? If yes, or planned, please provide examples *No*

Metric 7 – Staff satisfaction	
18	Has your trust planned any targeted actions to increase the workplace satisfaction of Disabled staff? If yes, or planned, please provide examples *Yes* *Workshops are planned in the trust with staff with disabilities and staff who are carers to discuss the results of the WDES 2020 and form its action plan going forward.*
Metric 8 – Reasonable adjustments	
19	Does your trust have a reasonable adjustments policy? *Yes – this forms part of the Attendance Management Policy*
20	Are costs for reasonable adjustments met through centralised or local budgets within the trust? *Local*
21	Please summarise any actions taken in the last 12 months to improve the reasonable adjustments process? *Staff are asked individually on a 121 on local induction with their new manager if they require any reasonable adjustments*

	Managers attend training on their responsibility to provide reasonable adjustments as part of their attendance management course with HR *Support from Access to Work and Access and Access to Work Mental Health (Reploy) is promoted on the staff intranet*
Metric 9 – Disabled staff engagement	
22	Does your trust have a Disabled Staff Network (or similar)? *Yes- The trust has a Equality Diversity Age and Safeguarding (EDAS) group.* If no, does your trust plan to establish a Disabled Staff Network (or similar) in the next 12 months?
23	Was your trust's 2019/20 WDES action plan co-developed with Disabled staff? *Yes* If yes, please provide details on how Disabled staff were involved *The 2019/20 action plan went before the trusts Equality, Disability Age and Safeguarding group and Equality Champions.* *The Trust Disability Staff Network is small. There are plans to encourage the growth of this through the WDES workshops.*
Metric 10 – Board representation	

24	Please describe any challenges that your organisation has experienced in collecting and reporting data for this metric *N/A*
25	Name and job title of the Board lead for the Workforce Disability Equality Standard *Alyson Hall, Director of Human Resources*
26	Please summarise any actions taken in the last 12 months to improve Board representation *N/A*
Supplementary	
27	Are there plans for your trust to merge with another trust in the next 12 months? *No* If yes, please provide details
28	Do you have any further comments about the WDES data collection 2020? *No*

WE ARE THE NHS:

People Plan 2020/21 - action for us all

Title: **WE ARE THE NHS: People Plan for 2020/2021 - action for us all**

Publishing approval reference: 0067

If you have any queries or would like further information, please contact: england.ournhspeople@nhs.net

This publication is available at www.england.nhs.uk/ournhspeople

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Contents

Thank you

The work to develop We are the NHS: People Plan 2020/21 – action for us all has been led by NHS England and NHS Improvement and Health Education England, with significant collaboration and contributions from people working across the NHS and the wider health and social care sectors. Our sincere thanks go to all those who have engaged in this plan's development, and we look forward to continuing to work together to bring about the changes needed to support our people, now and for the long term.

Rankin

Rankin, the acclaimed and renowned photographer, captured 12 of our people working in different roles across the NHS. He offered to take these powerful portraits as a tribute and thank you to our people for their response to the COVID-19 pandemic, as well as to inspire generations to come.

ADE WILLIAMS
Superintendent pharmacist

ALI ABDI
Porter

ANNE ROBERTS
District nurse

CLAUDIA ANGHEL
Midwife

EMMA KELLY
Critical care nurse

FARZANA HUSSAIN
GP

JACK HANNAY MANIKUM
111 call handler

LAURA ARROWSMITH
COVID-19 ward cleaner

MARC LYONS
ICU consultant

ROOPAK KHARA
General adult psychiatrist

SARAH JENSEN
Chief information officer

STUART BROOKFIELD
Paramedic

Introduction and summary

Our NHS is made up of 1.3 million people who care for the people of this country with skill, compassion and dedication.

Action from the Interim People Plan was already being taken to increase the support and recognition for our people. Then the start of COVID-19 changed everything. Colleagues and loved ones were lost, and our people gave more of themselves than ever before. The public responded with appreciation and warmth. The clapping has now stopped, but our people must remain at the heart of our NHS, and the nation, as we rebuild.

This document sets out what the people of the NHS can expect – from their leaders and from each other – for the rest of 2020 and into 2021.

About this plan

This plan sets out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care.'The principles underpinning the action through 2020/21 must endure beyond that time'

The NHS is made up of people in many different roles, in different settings, employed in different ways, by a wide range of organisations. Many people providing NHS services work for NHS trusts.

But others are employed by community interest and other companies or partnerships – for example, in primary care across GP practices, dental surgeries, pharmacies and optometrists.

The NHS also works closely with partners in social care and local government, as well as with the voluntary and independent sectors. We benefit from the contribution of those in unpaid roles too – particularly carers and volunteers.

How different elements of the plan are implemented will vary across these different settings, but the principles it sets out apply across all organisations, and to all our people involved in providing or commissioning NHS care.

NHS England and NHS Improvement and Health Education England (HEE) will work with non-NHS employers and their representatives too, to agree how they support delivery of these principles in their organisations. Local systems and clinical commissioning groups (CCGs) need to do the same for services they commission.

Systems have an important role in leading and overseeing progress on this agenda, strengthening collaboration among all health and care partners – particularly with social care – to meet the complex and evolving staffing needs of our services.

What our people need

Our NHS people have been under increasing pressure since the response to COVID-19 began, and there will be further challenges ahead. Workload remains a pressing concern and we have all been reminded how critical it is to look after our people – and that we need to do more.

To address this now, and for the future, the NHS needs **more people, working differently, in a compassionate and inclusive culture:**

- **more people** in training and education, and recruited to ensure that our services are appropriately staffed
- **working differently** by embracing new ways of working in teams, across organisations and sectors, and supported by technology
- **in a compassionate and inclusive culture** by building on the motivation at the heart of our NHS to look after and value our people, create a sense of belonging and promote a more inclusive service and workplace so that our people will want to stay.

This plan sets out practical actions that employers and systems should take, as well as the actions that NHS England and NHS Improvement and Health Education England will take over the remainder of 2020/21. It focuses on:

- **Looking after our people** particularly the actions we must all take to keep our people safe, healthy and well – both physically and psychologically.
- **Belonging in the NHS** highlighting the support and action needed to create an organisational culture where everyone feels they belong.
- **New ways of working and delivering care** emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care.
- **Growing for the future** particularly by building on the renewed interest in NHS careers to expand and develop our workforce, as well as retaining colleagues for longer.

During the COVID-19 response so far, people have shown energy, creativity and drive in finding solutions to new problems. The NHS needs to harness that, as part of our commitment to make real and lasting change for our people.

The way this plan is translated into action will differ for each setting. But its intention and ambition should be carried through into our many different teams, organisations and systems. Each of us has a part to play in making this a lasting change. This is a task not just for human resources teams and senior leaders, but for everyone in the NHS.

Systems have a particularly important role to play, as set out in NHS system planning guidance. As a minimum, all systems should develop a local People Plan in response to 'We are the NHS: People Plan 2020/21 - action for us all'. Many organisations may wish to do one for their individual organisations as well, which we encourage.

The purpose is to make sure that plans for recovery and stepping services back up through the remainder of 2020/21 have a strong focus on looking after our people, are aligned with service and financial plans, and are developed alongside partners – including in social care and public health.

These local People Plans should be reviewed by regional and system People Boards, and should be refreshed regularly in response to changes in demand or services.

The NHS has worked in partnership with social care during the pandemic so far, to provide support and to share workforce where possible. This was underpinned by the government's care homes support plan as well as joint work at national and local level to support staff to return to the health and care sector, although only a small number were deployed into care homes. In order to ensure that social care has the support it needs in preparation for winter and future outbreaks, the NHS and social care should continue to work in close partnership at every level. In particular all systems should review their local workforce position with providers and implement arrangements for their areas to increase resilience and capability.

Action will need to continue beyond 2020/21

This plan focuses on the national and local steps that need to be taken for the rest of 2020/21 to support our people and help manage the pressures and uncertainty that will continue to be felt. The conversations that inform the local plans will be as important as the plans themselves.

However, transformation is an ongoing process and work will continue beyond 2020/21 in all the areas set out in this plan. In addition, when the government further clarifies the available budget to expand the workforce and make sure that education and training is fit for the future – as expected to be set out in the forthcoming spending review – more details will follow.

ALI ABDI

Porter, University Hospitals Bristol and Weston NHS Foundation Trust.

1 Responding to new challenges and opportunities

In June 2019, NHS England and NHS Improvement and Health Education England published the Interim People Plan. Many of the challenges it highlights endure, and many of the actions it set out have been implemented across the country, at pace, in response to COVID-19.

"It doesn't feel like we ever stood back and truly reflected on what we had done; we were just going flat out for several weeks – no weekends, no breaks and no leave. The NHS is the best thing about the UK, hands down. Everyone pulls together in times like this and it's the one place people know they can rely on for help, no matter what their status or background, because that's what it was created for and that's what we do."

Chief information officer, London

Here are highlights of a small selection of the profound changes that have emerged through the COVID-19 response so far:

Health and wellbeing of our people: There has been a greater focus on the health and wellbeing of our colleagues, with support offered in teams and organisations. This includes psychological support, Schwartz Rounds, and workplace wobble rooms. Systems have played a key role in providing a co-ordinated approach.

There has also been greater recognition and support for working carers through the launch of the carers passport. The public and the private sector have also made generous offers to the NHS as well as donating supplies and support – for example, through 'first class lounges'.

- **Shared purpose and permission to act:** Some governance and decision-making has been simplified, with clear outcomes specified, which has helped many people feel empowered to implement changes that have benefited patients, working with more autonomy. COVID-19 has also been a catalyst for greater local partnership and system working, with one forum for partners to agree actions in response to offers.

- **Highlighting existing and deep-rooted inequalities:** The disproportionate impact of COVID-19 on BAME communities and colleagues has shone a light on inequalities and created a catalyst for change. NHS leaders have stepped up, role modelling compassionate, inclusive leadership through open and honest conversations with teams, creating calls to action for boards, and strengthening the role of BAME staff networks in decision-making.

- **Flexible and remote working:** This has increased significantly in the NHS, with the average number of weekday remote meetings rising from 13,521 to 90,253 in weeks 1 to 8 of lockdown. This has enabled teams to run virtual multidisciplinary team meetings, case presentations and handovers, and teaching sessions. Many colleagues across the NHS have noted that this has been more productive, with less time spent travelling (with the additional benefit of reduced air pollution), and better turnout at meetings, as well as improved work-life balance.

- **Remote consultations:** Digital transformation has occurred rapidly across the NHS, with around 550,000 video consultations taking place in primary and secondary care, and 2.3 million online consultation submissions to primary care, in June. Video consultations are now used widely, including in community and mental health services, and in ambulance services. This has enabled staff across primary, community and secondary care to work differently, with some choosing to do part of their work from home.

- **Returning and new staff:** NHS staff numbers have been bolstered by clinicians returning from academia, retirement and other industries. Students have stepped out of training to increase their direct support to patient care. Staff have been redeployed to areas experiencing pressure.

  The role of NHS 111 has increased significantly, with more than 500 GPs returning to work alongside 1,000 locums and other GPs to support the Coronavirus Clinical Assessment Service (CCAS) – a new pathway within 111 for callers with more serious symptoms who did not need immediate acute referral but did require further assessment and follow up. This has been possible because our people, past and present, wanted to contribute to the NHS effort, supported by new arrangements and agreements devised behind the scenes.

- **Innovative roles:** Our existing NHS people have taken on new roles. For example, healthcare scientists have been deployed into critical care roles in Nightingale hospitals.

  Physiotherapists supporting intensive care units (ICUs) have been upskilled to carry out respiratory-related assessment and treatment – improving relationships across multidisciplinary teams and increasing appreciation of each other's skills. Advanced clinical practitioners have also stepped up, contributing valuable clinical support in critical care and emergency medicine.

- **Support for care homes:** The NHS rolled out a clinical support package which provided a named clinical lead for every care home, as well as wider NHS primary and community support including weekly virtual check-ins, care plans, and medication reviews.

- **Volunteering:** There has been a huge surge in people volunteering to support those in need of help. Thousands have signed up to national and local initiatives, including Rapid Responders through the GoodSAM campaign. This has brought great opportunities and also challenges to make sure that volunteers are deployed safely and effectively.

- **Research:** Our NHS people have also played a key role in COVID-19 research – in particular, supporting the Recovery (Randomised Evaluation of COVID-19 therapy) programme. This is the world's biggest randomised clinical trial and pools the resources and skills of the NHS with those of our world-leading life sciences sector.

  Teams of research nurses and clinical trial assistants have been rapidly assembled to provide a seven-day service to identify and recruit patients. Its success is already improving patient care.

Not everything that happened in the first phase of the COVID-19 response will have been successful for every individual, team and organisation. Our learning from the pandemic is only just beginning. But already, we have seen dramatic changes across the NHS.

Where new approaches have worked well, we should not roll them back but adopt them systematically. Where they haven't, we must all learn and find other, better ways.

To successfully innovate, we need to measure the impact to see what works. This will ensure that the NHS rebuilds in a way that is even better than before.

To turn this plan into reality, metrics to accompany and track the impact of the actions in this plan will be developed in partnership with systems and stakeholders by the end of September 2020.

Accountability for delivering outcomes will be at all levels of the system and NHS England and NHS Improvement will continue to track progress on people and workforce issues using the NHS Oversight Framework, providing support and challenge to systems and organisations to make progress across this agenda.

FARZANA HUSSAIN

GP, Project Surgery, Newham.

2 Looking after our people

The NHS achieves extraordinary things for patients, but safety and health and wellbeing matter just as much for our people. If we don't look after ourselves, and each other, we cannot deliver safe, high-quality care. COVID-19 has spurred the NHS on to put much greater focus on this, which we must continue and build on.

The pandemic has already had a significant physical, mental and psychological impact on our people – and this will continue for some time to come. Many people are tired and in need of rest and respite. Evidence tells us that those in caring roles often wait until they are very unwell before raising their hand. So we must all encourage each other to seek help – and seek it as soon as it is needed. And leaders, teams and employers must keep offering people support to stay well at work, and keep offering it consistently, across teams, organisations and sectors.

Our NHS People Promise

This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone.

The themes and words that make up Our People Promise have come from those who work in the NHS. We asked people working in different healthcare roles and organisations to tell us what matters most to them, and what would improve their experience of working in the NHS.

The descriptions in Our People Promise are what we should all be able to say about working in the NHS, by 2024. For many, some parts of the Promise will already match their current experience. For others, it may still feel out of reach. We must pledge as colleagues, line managers, employers and central bodies to work together to make these ambitions a reality for all of us, within the next four years.

The people best placed to say when progress has been made are those who work in the NHS. From 2021, the annual NHS Staff Survey will be redesigned to align with Our People Promise. Using the Staff Survey as the principal way to measure progress will enable teams and departments, as well as whole organisations, to see their progress and take action to improve.

Only by making Our People Promise a reality will the NHS become the best place to work for all of us – where we are part of one team that brings out the very best in each other.

The rest of this plan sets out actions that we must all focus on through 2020/21.

PEOPLE IN ACTION...

Milton Keynes University Hospitals NHS Trust: looking after our people

Since the introduction of a staff benefits programme, more people from the 4,500-strong workforce have wanted to stay on at Milton Keynes University Hospital NHS Trust and fewer people have left. Adelaide Atu, Senior Sister, commented: "No matter what grade you are, it's easy to get the support you need."

FIND OUT MORE...

Support during COVID-19 so far

Through the COVID-19 response to date, individuals and teams have done a huge amount to support each other, including regular team check-ins, and making space available for colleagues to rest and recuperate. There has also been a widespread outpouring of support from the public and businesses.

Nationally, NHS England and NHS Improvement built on this with an offer made to all NHS staff on people.nhs.uk with:

- a dedicated health and care staff support service, including confidential support via phone and text messages
- specialist bereavement support
- free access to mental health and wellbeing apps
- guidance for key workers on how to have difficult conversations with their children
- group and one-to-one support, including specialist services to support our black, Asian and minority ethnic (BAME) colleagues
- mental health resources and support, including for people affected by suicide
- a series of webinars providing a forum for support and conversation with experts.

NHS England and NHS Improvement also developed guidance to equip NHS line managers to effectively support and lead their teams during and after the COVID-19, including

- coaching and mentoring support
- online resources, toolkits and guidance on topics such as maintaining team and individual resilience; managing stress and maintaining routines; compassionate

leadership in a crisis; and creating time and space to support teams working under pressure. REACT mental health conversation training was also provided to enable managers to support staff through compassionate, caring conversations about mental health and emotional wellbeing.

These interventions helped our people feel more valued and supported. Now, we must build on this, so they continue to feel this way.

We are safe and healthy

The safety and health of our people is paramount. In the early response to COVID-19, when so little was known about the disease, coming to work required the courage associated more with roles in the military than healthcare. Employers across the NHS must now continue to take all necessary measures and redouble their efforts to keep people safe, or risk them leaving.

Employers' focus should be on the following areas, which are the ones staff say they care most about:

- **Infection risk:** Employers should put in place effective infection prevention and control procedures, including social distancing and redesigning care procedures that pose high risks for spread of infections.
- **Providing PPE:** Employers should make sure all their people have access to appropriate personal protective equipment (PPE) and are trained to use it.

> **"The introduction of a wellbeing room has been brilliant and more focus on staff wellbeing going forward is paramount."**
>
> **Physiotherapist,** Midlands

- **Flu vaccination:** Frontline healthcare workers involved in direct patient care are encouraged to receive seasonal influenza vaccination annually to protect themselves and their patients from influenza. All frontline healthcare workers should have a vaccine provided by their employer. Public Health England will continue to monitor performance on uptake.
- **Risk assessment for vulnerable staff:** All NHS organisations will complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed. Organisations are encouraged to expand this to all staff.
- **Home-working support:** Employers should make sure people working from home can do safely and have support to do so, including having the equipment they need.
- **Rest and respite:** Employers should make sure their people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way.

PEOPLE IN ACTION...

Norfolk and Waveney STP: from kindness to innovation

Kindness, team work, flexibility and innovation are some of the emerging themes from the stories of people like community pharmacist Gregory Arthur through the new health and wellbeing network set up by Norfolk and Waveney STP in response to the pandemic.

FIND OUT MORE...

- **Bullying and harassment:** All employers are responsible for preventing and tackling bullying, harassment and abuse against staff, and for creating a culture of civility and respect. By March 2021, NHS England and NHS Improvement will provide a toolkit on civility and respect for all employers, to support them in creating a positive workplace culture.
- **Violence against staff:** Leaders across the NHS have a statutory duty of care to prevent and control violence in the workplace – in line with existing legislation – so that people never feel fearful or apprehensive about coming to work. NHS England and NHS Improvement have developed a joint agreement with government to ensure action in response to violence against staff. By December 2020, an NHS violence reduction standard will be launched, to establish a systematic approach to protecting staff.

We invest in our physical and mental health and wellbeing

As a good employer, it is our moral imperative to make sure our people have the practical and emotional support they need to do their jobs. Each of us must build on the support given during the COVID-19 response and make sure it continues.

Staff should expect their employers to address the following areas:

- **All organisations to have a wellbeing guardian:** NHS organisations should have a wellbeing guardian (for example, a non-executive director or primary care network clinical director) to look at the organisation's activities from a health and wellbeing perspective and act as a critical friend, while being clear that the primary responsibility for our people's health and wellbeing lies with chief executive officers or other accountable officers.

- **All staff supported to get to work:** NHS organisations should continue to give their people free car parking at their place of work for the duration of the pandemic. Organisations should also support staff to use other modes of transport, and hospitals should identify a cycle-to-work lead so that more staff can make use of this option.

- **Safe spaces for staff to rest and recuperate:** Employers should make sure that staff have safe rest spaces to manage and process the physical and psychological demands of the work, on their own or with colleagues.

- **Psychological support and treatment:** Employers should ensure that all their people have access to psychological support. NHS England and NHS Improvement will continue to provide and evaluate the national health and wellbeing programme developed throughout the COVID-19 response.

  NHS England and NHS Improvement will continue to provide and evaluate the national health and wellbeing programme developed throughout the COVID-19 response. It will also pilot an approach to improving staff mental health by establishing resilience hubs working in partnership with occupational health programmes to undertake proactive outreach and assessment, and co-ordinate referrals to appropriate treatment and support for a range of needs.

- **Support for people through sickness:** Employers should identify and proactively support staff when they go off sick and support their return to work. NHS England and NHS Improvement will pilot improved occupational health support in line with the SEQOHS standard. Working in selected pilot areas, in partnership with the resilience hub and local mental health services, occupational health services will provide a wider wellbeing offer, to ensure that staff are supported to stay well and in work.

- **Physically healthy work environments:** Employers should ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day – especially where their roles are more sedentary.

- **Support to switch off from work:** Employers should make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout. To do this, they must make sure staff understand that they are expected to take breaks, manage their work demands together and take regular time away from the workplace. Leaders should role model this behaviour.

PEOPLE IN ACTION...

Gloucestershire Hospitals NHS Trust: an essential nutrient for staff wellbeing

"Rather than being seen as the 'cherry on the cake', we hope that psychology can act more like yeast and salt in the trust, present throughout; enriching, enhancing, preserving and an essential nutrient." Dr Polly Ashworth explains how collaborative support for staff wellbeing is proving its worth at Gloucestershire Hospitals NHS Trust.

FIND OUT MORE...

Health and wellbeing conversations and personalised plans

From September 2020, every member of the NHS should have a health and wellbeing conversation and develop a personalised plan. These conversations may fit within an appraisal, job plan or one-to-one line management discussion, and should be reviewed at least annually.

As part of this conversation, line managers will be expected to discuss the individual's health and wellbeing, and any flexible working requirements, as well as equality, diversity and inclusion. From October 2020, employers should ensure that all new starters have a health and wellbeing induction.

We work flexibly

To become a modern and model employer, we must build on the flexible working changes that are emerging through COVID-19. This is crucial for retaining the talent that we have across the NHS. Between 2011 and 2018 more than 56,000 people left NHS employment citing work-life balance as the reason. We cannot afford to lose any more of our people.

Many people in the NHS go on to bank rotas, become locums, or leave us altogether because they are not offered the flexibility they need to combine work with their personal commitments. The NHS has a higher-than-average proportion of people with caring responsibilities and COVID-19 has also changed the responsibilities for many – particularly those with significant caring duties.

Flexible working means different things to different people and can relate to when, where and how we work. It can also include the need for greater predictability, to help people manage their different responsibilities and broader interests.

Getting this right requires managers and leaders to take the time to understand what each person needs. That way, employers can help them incorporate work more easily into the rest of their lives. Making flexible working a reality for all our people will need compassionate conversations between employers and staff representatives.

Employers are encouraged to make progress for their people in the following areas:

- **Flexibility by default:** Employers should be open to all clinical and non-clinical permanent roles being flexible. From January 2021, all job roles across NHS England and NHS Improvement and HEE will be advertised as being available for flexible working patterns. From September 2020, NHS England and NHS Improvement will work with the NHS Staff Council to develop guidance to support employers to make this a reality for their staff.
- **Normalise conversations about flexible working:** Employers should cover flexible working in standard induction conversations for new starters and in annual appraisals. Requesting flexibility – whether in hours or location – should not require a justification, and as far as possible should be offered regardless of role, team, organisation and grade.
- **Flexibility from day one:** NHS organisations should consider it good practice to offer flexible working from day one, as individual circumstances can change without warning.
- **Role modelling from the top:** Board members must give flexible working their focus and support. NHS England and NHS Improvement will add a key performance indicator on the percentage of roles advertised as flexible at the point of advertising to the oversight and performance frameworks.
- **E-rostering:** NHS England and NHS Improvement will support organisations to continue the implementation and effective use of e-rostering systems, accelerating roll-out where possible. These systems promote continuity of care and safe staffing, enable colleagues to book leave and request preferred working patterns up to 12 weeks in advance, and can also be used to support team rostering.

- **Management support:** Working with the national NHS Staff Council, NHS England and NHS Improvement will develop online guidance and training on flexible working by December 2020. This will be aimed at staff and managers alike, reinforcing the benefits and providing the tools to develop and assess applications for flexible working, with a view to supporting flexibility as a default.
- **Flexibility in general practice:** NHS England and NHS Improvement will work with professional bodies to apply the same principles for flexible working in primary care, which is already more flexible than other parts of the NHS. Building on pilots, it will encourage GP practices and primary care networks to offer more flexible roles to salaried GPs and support the establishment of banks of GPs working flexibly in local systems.
- **Flexibility for junior doctors:** During the rest of 2020/21, Health Education England will continue to increase the flexibility of training for junior doctors, such as less than full-time training, out-of-programme pauses and opportunities to develop portfolio careers. Full roll-out will happen by 2022/23, so that all junior doctors will be able to apply for flexibility in their chosen training programme.
- **Supporting people with caring responsibilities:** Employers should roll out the new working carers passport to support timely, compassionate conversations about what support would be helpful, including establishing and protecting flexible working patterns. We encourage employers to learn from best practice in this area.

HR and OD professionals have a key role to play

Human resources (HR) and organisational development (OD) professionals are critical to the NHS and will play a major part in driving the implementation of this plan, whatever the size of organisation they work in.

They can help the NHS attract and retain more people, embed a compassionate and inclusive culture, create an increasingly multidisciplinary and adaptive workforce, and drive different and more flexible working practices. Professionals leading HR and OD work also play a crucial role in smaller organisations and in primary care. NHS England and NHS Improvement will establish a diverse steering group of senior NHS leaders and experts from a range of sectors to support the Chief People Officer's review of HR and OD, which will report by the end of 2020/21.

EMMA KELLY

Critical Care Nurse,
Manchester University
NHS Foundation Trust.

3 Belonging in the NHS

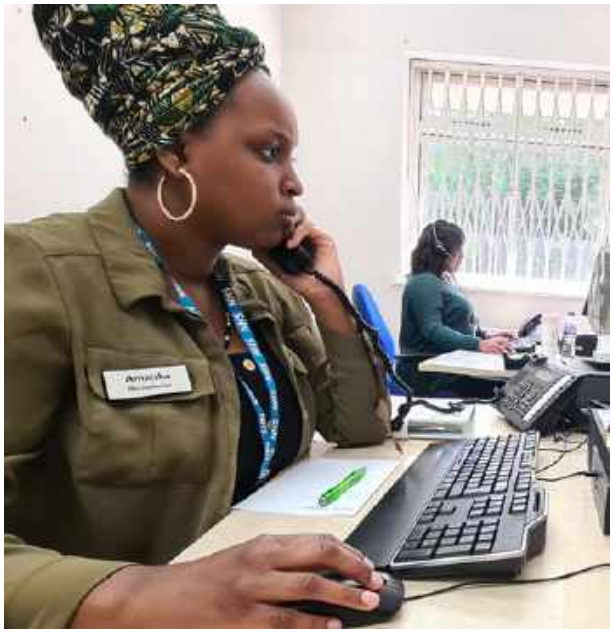
NHS staff have been challenged by the response to COVID-19 on a scale and at a pace not previously seen. These pressures have, on the whole, brought out the very best in our leaders – with compassionate and inclusive leadership behaviours coming to the fore. Clinical leadership and distributed leadership have also proved to be more critical than ever in recent months.

We must continue our efforts to make the culture of the NHS universally understanding, kind and inclusive, through the testing times that lie ahead.

The NHS will be open and inclusive

The NHS was established on the principles of social justice and equity. In many ways, it is the nation's social conscience, but the treatment of our colleagues from minority groups falls short far too often. Not addressing this limits our collective potential. It prevents the NHS from achieving excellence in healthcare, from identifying and using our best talent, from closing the gap on health inequalities, and from achieving the service changes that are needed to improve population health.

Given recent national and international events, it has never been more urgent for our leaders to take action and create an organisational culture where everyone feels they belong – in particular to improve the experience of our people from black, Asian and minority ethnic (BAME) backgrounds.



"All our jobs have become more difficult and we have to take extra special care to look after our patients, ourselves and each other. It's a difficult time but we are pulling together as a team. Everyone is pushing themselves and doing an amazing job. I couldn't be prouder of them all.

That's probably why, even after 15 years, I still love and would recommend my job. The NHS has a way of attracting so many different people from all walks of life – and making them all feel they belong."

Hospital porter, South West

The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms. Discrimination, violence and bullying have no place. If we do not role model this culture, then how can our patients expect to be treated equitably, and as individuals?

A time of national awakening

COVID-19 has intensified social and health inequalities. The pandemic has had a disproportionate impact on our BAME colleagues, families, and friends; on older people; on men; on those with obesity; and on those with a disability or long-term condition.

The NHS is the largest employer of BAME people in the country and BAME colleagues have lost their lives in greater numbers than any other group. We must take seriously our responsibility to look after at-risk staff, prioritising physical and psychological safety.

Systemic inequalities are not unique to the NHS. Each of us must listen and learn – from our colleagues, and from society – and take considered, personal and sustained action to improve the working lives of our NHS people and the diverse communities we serve.

There is strong evidence that where an NHS workforce is representative of the community that it serves, patient care and the overall patient experience is more personalised and improves. Yet it is also clear that in some parts of the NHS, the way a patient or member of staff looks can determine how they are treated.

The Workforce Racial Equality Standard (WRES) has led to progress across a number of areas; for example, increases in the proportion of BAME very senior managers.

NHS England and NHS Improvement, with the NHS Confederation, has now established the NHS Race and Health Observatory. This body will bring together experts from this country and internationally, to provide analysis and policy recommendations to improve health outcomes for NHS patients, communities and our people. This will be crucial for building evidence and driving progress.

The Workforce Disability Equality Standard (WDES) has begun to shine a light on the difficulties that colleagues with disabilities and long-term health conditions face. But there remain challenges. For example, we know that the majority of staff who identify as LGBTQ+ do not feel confident enough to report their sexuality on their employment record.

To realise urgent change, we must work systematically and give these issues the same emphasis as we would any other patient safety-related concern. We must act with integrity, intelligence, empathy, openness and in the spirit of learning.

To do this, we each need to first examine our personal track record on, and commitment to, equality, diversity and inclusion.

Staff should expect their employers to take action on the following areas:

- **Recruitment and promotion practices:** By October 2020, employers, in partnership with staff representatives, should overhaul recruitment and promotion practices to make sure that their staffing reflects the diversity of their community, and regional and national labour markets. This should include creating accountability for outcomes, agreeing diversity targets, and addressing bias in systems and processes. It must be supported by training and leadership about why this is a priority for our people and, by extension, patients.

  Divergence from these new processes should be the exception and agreed between the recruiting manager and board-level lead on equality, diversity and inclusion (in NHS trusts, usually the chief executive).

- **Health and wellbeing conversations:** From September 2020, line managers should discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the previous chapter, to empower people to reflect on their lived experience, support them to become better informed on the issues, and determine what they and their teams can do to make further progress.

- **Leadership diversity:** Every NHS trust, foundation trust and CCG must publish progress against the Model Employer goals to ensure that at every level, the workforce is representative of the overall BAME workforce. From September 2020, NHS England and NHS Improvement will refresh the evidence base for action, to ensure the senior leadership (very senior managers and board members) represents the diversity of the NHS, spanning all protected characteristics.

- **Tackling the disciplinary gap:** Across the NHS we must close the ethnicity gap in entry to formal disciplinary processes. By the end of 2020, we expect 51% of organisations to have eliminated the gap in relative likelihood of entry into the disciplinary process. For NHS trusts, this means an increase from 31.1% in 2019. As set out in A Fair Experience for All, NHS England and NHS Improvement will support organisations in taking practical steps to achieving this goal, including establishing robust decision-tree checklists for managers, post action audits on disciplinary decisions, and pre-formal action checks.

- **Governance:** By December 2021, all NHS organisations should have reviewed their governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.

  Not only do staff networks provide a supportive and welcoming space for our people, they have deep expertise on matters related to equality, diversity and inclusion, which boards and executive teams need to make better use of. Staff networks should look beyond the boundaries of their organisation to work with colleagues across systems, including those working in primary care.

- **Information and education:** From October 2020, NHS England and NHS Improvement will publish resources, guides and tools to help leaders and individuals have productive conversations about race, and to support each other to make tangible progress on equality, diversity and inclusion for all staff. The NHS equality, diversity and inclusion training will also be refreshed to make it more impactful and focused on action.

- **Accountability:** By March 2021, NHS England and NHS Improvement will have published competency frameworks for every board-level position in NHS providers and commissioners. These frameworks reinforce that it is the explicit responsibility of the chief executive to lead on equality, diversity and inclusion, and of all senior leaders to hold each other to account for the progress they are making.

- **Regulation and oversight:** Over 2020/21, as part of its 'well led' assessment of trusts, the Care Quality Commission (CQC) will place increasing emphasis on whether organisations have made real and measurable progress on equality, diversity and inclusion - and whether they are able to demonstrate the positive impact of this progress on staff and patients.

- **Building confidence to speak up:** By March 2021, NHS England and NHS Improvement will launch a joint training programme for Freedom to Speak Up Guardians and WRES Experts. We are also recruiting more BAME staff to Freedom to Speak Up Guardian roles, in line with the composition of our workforce.

PEOPLE IN ACTION...

West Yorkshire and Harrogate Partnership: moving diverse leadership forward

"The experience of BAME colleagues, like my own, is important to how we move forward." Fatimah Khan-Shah explains how West Yorkshire and Harrogate Partnership is putting diverse leadership at the heart of its ICS workforce strategy, to address the disproportionately high poor experiences in the workplace for BAME staff.

FIND OUT MORE...

Ensuring staff have a voice

We all need to feel safe and confident when expressing our views. If something concerns us, we should feel able to speak up. If we find a better way of doing something, we should feel free to share it. We must use our voices to shape our roles, workplace, the NHS, and our communities, to improve the health and care of the nation.

We also need to take the time to really listen, helping one another through challenges and during times of change, and making the most of new opportunities. Many staff have felt unable to speak up, or that they have been ignored. This is another area in which BAME staff have been particularly affected. We need to look beyond the data and listen to the lived experience of our colleagues. When our people speak, we must listen and then take action.

The experience of COVID-19 has thrown into even sharper relief the need to engage with and listen to our people. NHS England and NHS Improvement have recently launched the NHS People Pulse for all NHS and provider organisations, to understand our NHS people's varied experience through COVID-19 and recovery. To build on this, we will now:

- adapt the 2020 NHS Staff Survey to reflect the current context
- explore options to implement this survey in primary care in the autumn
- launch a new quarterly staff survey to track people's morale in the first quarter of 2021/22, following the results of the 2020/21 National Staff Survey.

But using surveys is just one important way to hear from our people. Networks and digital spaces are also important ways to convey staff experiences. Making sure staff are empowered to speak up – and that

when they do, their concerns will be heard – is essential if we are to create a culture where patients and staff feel safe. We must all make sure our people feel valued, and confident that their insights are being used to shape learning and improvement.

NHS England and NHS Improvement will work with the National Guardian's office to support leaders and managers to foster a listening, speaking up culture. Board members of NHS trusts and foundation trusts already have specific responsibilities under the NHS Improvement board guidance published in July 2019.

We will also promote and encourage employers to complete the free online Just and Learning Culture training and accredited learning packages to help them become fair, open and learning organisations where colleagues feel they can speak up.

As employers, NHS England and NHS Improvement and Health Education England will also take demonstrable action to model these leadership behaviours.

Compassionate and inclusive leadership

Inclusive cultures depend on inclusive leaders. Powerful leadership can be found at all levels, across all roles, and in all teams in the NHS. In the first phase of the response to the COVID-19 pandemic, the power and significance of clinical leadership came to the forefront. We have also heard that people felt they were given licence to exercise their leadership, irrespective of title and grade.

The NHS must build on this distributed leadership that has emerged in recent months. All leaders in the NHS, particularly those who hold formal management and leadership positions, are expected to act with kindness, prioritise collaboration, and foster creativity in the people they work with.

"The most important thing has been giving power to front line teams… In the past, many barriers were in place to making changes, with centralised decision-making that stifled innovation. In COVID-19 early stages, national oversight stepped back in response to the emergency, and clinical teams were able to self-govern, innovate and collaborate to implement changes that met the immediate needs of their patients. My main urge would be to remember that NHS staff have moved mountains to reply to the pandemic. Leaders please trust frontline staff to do what is needed and empower them to deliver the best for their own patients."

Hospital doctor, Midlands

With the right leadership, NHS teams can flourish. That is why we must prioritise support to line managers and leaders to develop their skills. This new approach to NHS leadership will be codified in a leadership compact that will be published shortly.

The following actions will be taken in 2020/21 to support leaders to continue building more compassionate and inclusive cultures in their teams:

- **Leadership development:** From September 2020, NHS England and NHS Improvement will provide refreshed support for leaders in response to the current operating environment. This will include expert-led seminars on health inequalities and racial injustice, and action learning sets for senior leaders across health and social care.
- **Clinical leadership by March 2021:** NHS England and NHS Improvement will work with the Faculty of Medical Leadership and Management to expand the number of placements available for talented clinical leaders each year. These roles will be based in systems, and will focus on improvement projects across clinical pathways.
- **Talent management:** By December 2020, NHS England and NHS Improvement will update the talent management process to make sure there is greater prioritisation and consistency of diversity in talent being considered for director, executive senior manager, chair and board roles. This will include clearer guidance on the recruitment process, and metrics to track progress.
- **Digital line management training:** By January 2021, NHS England and NHS Improvement will launch an updated and expanded free online training material for all NHS line managers. For those who seek to progress, a management apprenticeship pathway will be launched.
- **Online leadership resources:** All central NHS leadership programmes will be available in digital form, and accessible to all, by April 2021. The curriculum will be updated to be underpinned by the principle of inclusion. It will include practical resources on team effectiveness, crisis management, retention and talent management.

- **Accountability:** In October 2020, NHS England and Improvement will publish a consultation on a set of competency frameworks for board positions in NHS provider and commissioning organisations. Once finalised, the frameworks will underpin recruitment, appraisal and development processes for these crucial leadership roles.

- **Response to Kark review:** Ensuring high standards of leadership in the NHS is crucial – well-led organisations and better-led teams with strong teamwork, translates into greater staff wellbeing and clinical care. NHS England and NHS Improvement have completed the engagement exercise commissioned by government in response to Tom Kark QC's review of the Fit and Proper Persons Test, and are working with the Department of Health and Social Care to finalise a response to the review's recom.

- **Developing our evidence base:** By March 2021, NHS England and NHS Improvement will have launched a new NHS leadership observatory which will highlight areas of best practice globally, commission research, and translate learning into practical advice and support for NHS leaders. The observatory will build on the results of the forthcoming national leadership development survey.

JACK HANNAY MANIKUM

111 call handler,
West Midlands
Ambulance Service.

4 New ways of working and delivering care

The challenge of COVID-19 has compelled the NHS to make the best use of our people's skills and experience, to provide the best possible patient care. People have risen to the challenge and have been flexible and adaptable – with many colleagues rapidly brought into services outside their normal scope of practice, and new teams created around people's experience and capabilities rather than traditional roles.

Successes in teams were made possible by good communication, high levels of trust, distributed leadership, and rapid decision-making, as bureaucracy fell away and people felt empowered to do what was needed. Teams also blurred sector boundaries, with greater collaborative working with colleagues in social care. We must all now build on this momentum to transform the way our teams, organisations and systems work together, and how care is delivered for patients.

"A remote 'Ask the Medical Reg' service was run by doctors unable to work in face-to-face contact for a number of reasons. This was a 24-hour service for GPs, surgical doctors and paramedics to call for help and support, follow-up of results of discharged patients, and so on, to ease the workload of the medical registrar on call, managing issues that require face-to-face contact. It worked really well."

Hospital doctor, South West

Support during COVID-19 so far

During the first phase of the COVID-19 response, the whole NHS – including employers and our people – needed reassurance that whatever new roles they took on were legal and covered by employers' indemnity. So NHS England and NHS Improvement worked with a wide range of key partners to develop guidance and establish a framework to ensure that our people were safely and legally deployed.

For example, staffing ratios in critical care were reviewed to ensure that there were enough staff in place to respond to the unprecedented demand for these skills. NHS bodies also worked in close partnership with other sectors, including supporting social care with infection prevention and control training. Meanwhile, academia and industry developed solutions to enable mass testing, technological advances and widescale remote working across the NHS, in response to the pandemic.

PEOPLE IN ACTION...

East Kent: sharing knowledge for a different mindset in health and social care

"We all started working with more collaboration, with a really different mindset emerging." Dr Rakesh Koria, GP lead for the Acute Response Team (ART) service in Thanet, East Kent describes how they have been able to give extra support to health and social care and enabled colleagues to increase their skills through virtual knowledge-sharing sessions.

» FIND OUT MORE...

Health and care systems deployed staff and students across organisations and sectors. Voluntary sector organisations of all sizes stepped forward to help the NHS – for example, supporting with hospital discharge – to free up our people to focus on other aspects of the response.

Making the most of the skills in our teams

The NHS's response so far to COVID-19 has shown how quickly and effectively our people can adapt to meet the needs of patients. Staff working and learning together in new multiprofessional teams was critical in meeting the new challenge. We must build on this, actively designing multi-professional teams around the full range of experience and capabilities of their clinical and non-clinical members, keeping patient and staff safety at the forefront.

"In response to pandemic surge demand, a rolling programme of clinical skills education enabled a cohort of 'B' nurses to be clinically prepared to support the critical care 'A' nurses in bedside delivery. More than 100 additional professionals were upskilled with critical care essentials and proning techniques. On return to their normal area of practice, they have taken their additional skills to enhance their practice, plus a collaborative appreciation of organisational services and ability and willingness for future redeployment."

Intensive care nurse South East

Staff should expect organisations and employers to focus on the following areas:

- **Supporting deployment and redeployment:** Employers should use guidance on safely redeploying existing staff and deploying returning staff, developed in response to COVID-19 by NHS England and NHS Improvement and key partners, alongside the existing tool to support a structured approach to ongoing workforce transformation.

- **Upskilling staff:** There should be continued focus on upskilling – developing skills and expanding capabilities - to create more flexibility, boost morale and support career progression. Systems should keep the need for local retraining and upskilling under review, working in partnership with local higher education institutions.

  There is wide recognition of the need for a nationally-recognised critical care qualification which is open to different professions. HEE will work with professional and regulatory bodies to provide this to offer continuing professional development opportunities for people wishing to specialise in this area. HEE is also working with the medical Royal Colleges and regulators to ensure that competencies gained by medical trainees while working in other roles during COVID-19 can be recognised and count towards training.

- **Technology-enhanced learning:** Employers and organisations should use HEE's e-Learning for Healthcare (e-LfH) programme and a new online Learning Hub, which was launched to support learning during COVID-19. They include resources and training on new ways of working, including GP remote consultations and remote triage; remote learning for colleagues being redeployed to ICU; and content for nurses, midwives, allied health professionals, radiographers, pharmacy staff and those working in the independent and social care sectors.

- **Developing generalist skills:** In July 2020, HEE published the Future Doctor report, which sets out the reforms needed in education and training to equip doctors with the skills that the future NHS needs and which have been much in demand during the COVID-19 response so far. During 2020/21, HEE will develop the educational offer for this generalist training and work with local systems to develop the leadership and infrastructure required to deliver it.

- **Primary care teams:** By the end of 2020/21, HEE will support the expansion of multidisciplinary teams in primary care, through the full roll out of primary care training hubs, to make sure there are enough people and leaders to create multidisciplinary teams that can respond to local population need.

PEOPLE IN ACTION...

Digital Nurse Network: supporting nurses across the NHS to use and promote digital services

"Little did we realise the impact that a global pandemic would have on the network. Almost overnight, nursing life changed and there was inevitably fear – but the nurse ethic to step up and make change at pace remained." Helen Crowther (left) and Ann Gregory explain how the Digital Nurse Network has been supporting nurses working within general practice and other care settings to use and promote digital services.

FIND OUT MORE...

Making the most of the skills and energy in our wider workforce

Volunteers have a played a vital role in supporting patients during the pandemic. Between April and July, in an unprecedented response, more than 360,000 members of the public volunteered through the NHS Volunteer Responders programme, offering their time and energy to support the NHS.

We must build on this incredible movement to support a renewed focus on increasing longer-term volunteering opportunities in the NHS. This is already being done, for example with the launch of the NHS Cadets - a new scheme set up with St John Ambulance, providing a chance to support patients and a new route into a future in the NHS. By 2023, NHS England and NHS Improvement aims to enrol 10,000 young people.

Organisations and systems are encouraged to focus on the following:

- **Training volunteers:** The National Learning Hub for Volunteering has been launched by HEE, and should be used to support the learning, training and development of volunteers across health, social care and the third sector.
- **Routes into employment for volunteers:** Systems and employers should review how volunteers can help support recovery and restoration, and develop plans to enable and support volunteers who wish to move on to employment opportunities across the NHS to do so. This must include a focus on providing opportunities for hard-to-reach groups, such as people with learning disabilities.
- **Inspiring the next generation:** Systems and employers should promote the NHS Ambassadors programme to their people and allow them time to do this valuable outreach work. The scheme supports NHS people to volunteer their time to connect with school children and young people, to showcase what we do and attract them into future careers in the NHS.

Educating and training our people for the future

In the first phase of the COVID-19 response, the NHS had to put many formal training pathways and placements on hold so that everyone could focus on the immediate priority of supporting patients. Now employers, line managers and supervisors must once again create the time and space for the training and development of our people, and our future colleagues, with a renewed emphasis on the importance of flexible skills and building capabilities rather than staying within traditionally-defined roles.

"I'm a second-year medical student at Birmingham University, and when coronavirus hit earlier this year, like many other students, we were told our exams were cancelled. We were, however, offered the chance to train as an NHS 111 call assessor – and I'm very pleased I did. It's a massive reward when you know you've helped someone, especially when they thank you at the end of the call. Even as doctors in training – all we want to do is help people to the best of our ability."

Medical student & 111 call handler,
West Midlands

This is expected to include:

- **Maintaining education to grow the future workforce:** Employers should fully integrate education and training into their plans to rebuild and restart clinical services, releasing the time of educators and supervisors to continue growing our workforce; supporting expansion of clinical placement capacity during the remainder of 2020/21; and also providing an increased focus on support for students and trainees, particularly those deployed during the pandemic response.

  For medical trainees, employers should ensure that training in procedure-based competencies is restored as services resume and are redesigned to sustain the pipeline of new consultants in hospital specialties.

- **Continuing professional development:** During 2020/21, employers must make sure our people have access to continuing professional development, supportive supervision and protected time for training. Employers have received new funding to support the continuing professional development of nurses, midwives and allied health professionals, equivalent to £1,000 per person over three years. Employers will need to support this investment through backfilling staff time during training.

- **Support for clinical placements:** To support employers in educating and training the next general of professionals, HEE is establishing a £10m fund for nurses, midwives and allied health professionals to drive increased placement capacity and the development of technology-enhanced clinical placements.

- **Expanding e-learning:** In 2020/21, HEE will further develop its e-learning materials, including simulation, building on the offer provided in response to COVID-19.

Investing in online education: From January 2021, several universities across England will start delivering a pre-registration blended learning nursing degree programme, commissioned by HEE. The programme aims to increase the appeal of a nursing career by widening access and providing a more flexible approach to learning, using current and emerging innovative and immersive technologies. HEE will also pursue this blended learning model for entry to other professions.

An additional starting point for nursing degrees – making a total of three intakes per year – responds to the surge in interest in, and applications to, nursing degrees as well as the demand from the NHS.

PEOPLE IN ACTION...

London Nightingale healthcare science workforce: working together differently

"The whole experience was exhausting but very rewarding. It has taught me a lot about the value of individuals who are both technically minded and clinically trained." Healthcare scientist Becky East describes her experience of being redeployed to the Nightingale Hospital in London.

FIND OUT MORE...

CLAUDIA ANGHEL

Midwife, University Hospital Coventry and Warwickshire.

5 Growing for the future

The NHS is experiencing significant and high-profile public support. We must build on this urgently, to recruit across our workforce, maximise participation and reverse the trend of early retirement.

Building on momentum

There is much more to be done to address the gaps in our workforce across various roles, professional groups and geographies. But if we are to address the pressures of workload and deliver the care patients need, we cannot delay in identifying what we need to do to grow our workforce. This is all the more critical as we face challenging times for international recruitment.

Since COVID-19 came in to our lives, there has been an unprecedented interest in careers in the NHS. Already, this interest has translated into higher numbers of applications to education and training (see box on the right). We must seize the opportunity to recruit directly into entry-level clinical roles, apprenticeships and non-clinical roles, refreshing our talent pipelines. We have also seen an overwhelming response to the call to recently retired and former staff to join the COVID response (see 'Focus on recruitment' section below). This suggests there is more we could do to encourage previous members of staff to rejoin the NHS.

Renewed interest in NHS careers

Interest in careers within the NHS continues to soar, with unprecedented hits on the newly revamped Health Careers website. The overall number of page visitors looking for information on training to be a nurse rose by 138% between March and June, with a 103% increase in people seeking information on becoming a paramedic. There was a 152% increase in interest in diagnostic radiography and a 218% rise in interest on becoming a high-intensity therapist.

This has already translated into healthy numbers of applications for a range of healthcare courses. We have seen more applications from UK-domiciled applicants than ever before, an increase in 18-year-old applicants in England, and the highest proportional growth in applicants from the most disadvantaged groups. In particular, nursing-related courses have seen a 17% rise in applicants and an increase in applicants from more mature age groups – reversing recent worrying trends – with a 32% increase in applicants for mental health nursing.

NHS England and NHS Improvement and HEE will continue to work with the government to achieve their commitments to expand the primary care workforce, including GPs and nurses. Work will happen over the rest of 2020/21 to determine the priorities.

Expanding and developing our workforce

HEE will make progress through 2020/21 in addressing the most pressing workforce shortages in those service areas with the highest demand and those professions that require urgent focus:

- **Mental health**: HEE is prioritising continued investment in training the future mental health workforce to support significant expansion in psychological therapies for children and young people, boosting the number of advanced clinical practitioners, psychiatrists and mental health nurses. In 2020/21 this will include enabling up to 300 peer-support workers to join the mental health workforce and expanding education and training posts for the future workforce, including over 100 additional responsible clinicians, 50 community-based specialist mental health pharmacists, nearly 3,000 adult IAPT practitioners, 245 children and young people's psychological wellbeing practitioners and 300 children and young people's IAPT practitioners.

  HEE is also increasing the number of training places for clinical psychology and child and adolescent psychotherapy by 25% (with 734 starting training in 2020/21) and investing in measures to expand psychiatry, starting with an additional 17 core psychiatry training programmes in 2020/21 in areas where it is hard to recruit, and the development of bespoke return to practice and preceptorship programmes for mental health nursing.

- **Cancer:** In 2021, HEE is prioritising the training of 400 clinical endoscopists and 450 reporting radiographers. Training grants are being offered for 350 nurses to become cancer nurse specialists and chemotherapy nurses, training 58 biomedical scientists, developing an advanced clinical practice qualification in oncology, and extending cancer support-worker training.

- **Advanced clinical practice:** In 2020/21, HEE is funding a further 400 entrants to advanced clinical practice training, supported by the Centre for Advancing Practice – to build on the success already seen in using advanced clinical practitioners to greater effect in multidisciplinary teams, both in primary and secondary care.
- **Expanding shortage specialties:** In 2020/21, HEE is investing in an extra 250 foundation year 2 posts, to enable the doctors filling them to grow the pipeline into psychiatry, general practice and other priority areas – notably cancer, including clinical radiology, oncology and histopathology.
- **Increasing undergraduate places:** HEE is working with universities to support an increase of over 5,000 undergraduate places from September 2020 in nursing, midwifery, allied health professions, and dental therapy and hygienist courses.
- **Developing clinical pharmacists:** To provide even more patient-centred care, a sustainable supply of prescribing pharmacists with enhanced clinical and consultation skills will be created. The key elements of the reform will be replacing the current pre-registration year with a foundation year, and enhancing clinical experience in initial education and training. This continuous, educational programme for pharmacists will still be five years in duration, and will link into advanced practice and research training. Working with stakeholders, and under the leadership of the General Pharmaceutical Council, the aim is to start this new approach from Summer 2021, building on HEE's Interim Foundation Programme that will commence in September 2020.

Focus on recruitment

While retaining our current workforce remains a priority, the NHS need to also renew efforts to rapidly recruit across all roles and professions. The significant surge in interest in careers in the NHS has been accompanied by wider changes to the labour market that have increased the pool of potential candidates. There is an urgent need to recruit new people to NHS Test and Trace, and to run an unprecedented winter flu vaccination campaign, as well as potentially a COVID-19 vaccination campaign.

We need to make the most of the current high profile of the NHS to recruit at pace and scale, focusing on domestic recruitment, international recruitment and encouraging staff to return to practice:

Local recruitment

- **Increasing local recruitment:** Employers must increase their recruitment to roles such as clinical support workers and, in doing so, highlight the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles.
- **Growing apprenticeships:** Employers should offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles. This is a key route into a variety of careers in the NHS, giving individuals the opportunity to earn and gain work experience while achieving nationally-recognised qualifications.
- **Expanding the primary care workforce:** Primary care networks, supported by systems and CCGs, should take immediate action to recruit additional roles funded by the Additional Roles Reimbursement Scheme, which will fund 26,000 additional staff until 2023/24.

International recruitment

- **Building local hubs:** Health systems have a key role in helping to resume international recruitment by supporting local international recruitment hubs. As part of NHS England and NHS Improvement's international recruitment nursing programme, we will incentivise trusts to develop lead-recruiter and system-level models of international recruitment, which will improve support to new starters as well as being more efficient and better value for money.
- **Increasing international recruitment:** NHS England and NHS Improvement and HEE are working with government to increase our ethical international recruitment and build partnerships with new countries, making sure this brings benefit for the person and their country, as well as the NHS. This will include work to remove barriers to recruitment and increasing capacity for induction and support.
- **English language training:** Recognising the high standards required by UK regulators, HEE will pilot English language programmes – including computer-based tests – across different regions, as well as offering English language training during 2020/21.
- **Co-ordinated international marketing:** NHS England and NHS Improvement will work with the government to establish a new international marketing campaign through 2020/21, to promote the NHS as an employer of choice for international health workers.

Health and care visa: In July 2020 the Government announced the introduction of a new Health and Care Visa, which will launch in August 2020. This visa will make it quicker, cheaper and easier for registered health staff to come from overseas to work in the NHS, the social care sector or for an organisation providing NHS commissioned services.

Those applying will be exempt from the Immigration Health Surcharge, benefit from 50% visa fee reductions and can an expect a decision within three weeks of their application, following biometric enrolment. Anyone else working in health or social care, who has paid the Immigration Health Surcharge on or after 31 March 2020 will be able to claim reimbursements for time they have worked in the sector, from October 2020.

Return to practice

Encouraging former staff to return to the NHS: Employers and systems, in partnership with social care, should encourage our former people to return to practice as a key part of their recruitment drive during 2020/21, building on the interest of some of the clinical staff who returned to the NHS to support the COVID-19 response, and have now expressed an interest in staying on in the health and care system (see box below).

NHS England and NHS Improvement and HEE will continue to work with professional regulators to support returners who wish to continue working in the NHS to move off the temporary professional register and onto the permanent register. This will include providing support to staff – to help meet revalidation requirements and ensure they feel confident when returning to practice – as well as helping find placements for them with employers. We will continue to work in partnership with social care to ensure that the thousands of nurses and other healthcare staff who temporarily returned to employment during COVID can continue to support the health and care system..

Supporting return to practice: HEE is exploring the development of a return to practice scheme for other doctors in the remainder of 2020/21, creating a route from temporary professional registration back to full registration. This would build on existing return to practice schemes for nurses, allied health professionals, GPs and pharmacists.

Encouraging return to clinical practice

In March 2020, the professional regulators for doctors, nurses and midwives, pharmacists and pharmacy technicians, and allied health professionals contacted over 65,000 former clinicians who had been out of practice for the last three years to invite them to join their tempory registers to support the NHS during the pandemic. This was followed up a few weeks later with a similar communication to former doctors, nurses and midwives who had left their professional register a few years earlier or whose licenses were no longer current.

There was an overwhelming response. At the time of publishing:

- **15,245** had completed pre-employment checks
- **8,755** had been deployed to acute services for employment
- **2,140** had been employed across NHS 111, NHS Test and Trace, acute trusts and social care.

The NHS was able to manage demand during the COVID-19 peak, so not as many of this group were needed as anticipated. But we cannot turn our back on this critical opportunity to boost our workforce with many experienced former clinicians.

A recent survey of returners revealed that around 50% were 'interested in continuing to work in the health and social care system in the medium to long term in some capacity'. Almost half of this group – 49% – are aged below 60.

PEOPLE IN ACTION...

Leeds Teaching Hospitals NHS Trust: new career pathway widens employment opportunities

Now a qualified nursing associate, Jenny Hiorns is ready to take the next step in her career thanks to the Future You model of step-on step-off clinical apprenticeships at Leeds Teaching Hospitals NHS Trust. The programme has helped LTHT to exceed the public sector apprenticeship target and provide employment to the local community.

FIND OUT MORE...

Retaining our people

The NHS needs to be bold and commit to offering more flexible, varied roles and opportunities for remote working. It is not always immediately easy to accommodate individual work preferences.

But if we do not take radical action to become a flexible and modern employer in line with other sectors, we will continue to lose people entirely or see participation rates decline. Staff should be able to expect their employers to focus on:

- **Varied roles:** Employers should design roles which make the greatest use of each person's skills and experiences, and fit with their needs and preferences. The NHS offers many varied opportunities with non-patient facing roles, including in NHS 111, clinical coaching and mentoring, teaching, research and much more. Systems and employers must make greater efforts to design and offer more varied roles to retain our people.

- **Retaining people approaching retirement:** Employers must do more to retain staff aged 55 years and over – who comprise over 19% of our workforce. Employers should ensure that staff who are mid-career (aged around 40 years) and, in particular, those approaching retirement (aged 55 years and over) have a career conversation with their line manager, HR and occupational health. This should be to discuss any adjustments needed to their role and their future career intentions. It should also include signposting to financial advice – in particular on pensions.

  Employers must make their people aware of the increase in the annual allowance pensions tax threshold, made in March 2020, which means that clinicians can earn an additional £90,000 before reaching the new taper threshold. This was designed to address the issue that some people in the NHS felt disincentivised from taking on additional work and leadership opportunities.

- **Facilitating opportunities to retire and return:** Employers must make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities.

  Under the current emergency rules, retired nurses and doctors are allowed to return to the NHS without impacting on their pension, and abatement for special class nurses between aged 55 and 60 years is suspended. This means they can do as much work as they like even after they have taken up their pension. The requirement that people work no more than two days a week for a month after taking their pension has also been suspended.

Retaining people in primary care: Systems should ensure that they are supporting their GP workforce through full use of the GP retention initiatives outlined in the GP contract, which will be launched in summer 2020.

Support for retention: NHS England and NHS Improvement's People Plan delivery programme (launching in summer 2020) will help NHS employers to value and retain their people by making their organisations a better place to work and being a modern and model employer. This will comprise a new online portal of resources, masterclasses and support for systems and organisations.

Alignment and collaboration across health and care systems

Our systems will be the key units in planning for recovery. They should support local health and care employers, as well as wider partners, with a concerted focus on people and workforce issues. This begins with greater alignment across workforce, operational and financial planning, with a bigger role for systems in understanding the numbers and skills of their workforce, and deploying them effectively to meet service requirements and local health needs.

Systems will have a central role in helping design new models of care and major service changes, to deliver better population health outcomes. They will need to work with HEE regional teams to understand the workforce requirements, any gap between demand and supply, and what needs to be done to address this.

Systems will also need to support the focus on retaining our people, including returners, as well as driving rapid, large-scale recruitment into a range of entry-level roles across the NHS. It will be critical to ensure a collaborative approach to recruitment, supporting primary and community care, as well as social care, to secure the skills and people they need.

The NHS has worked in partnership with social care during the pandemic so far, to provide support and to share workforce where possible. This was underpinned by the government's care homes support plan as well as joint work at national and local level to support staff to return to the health and care sector, although only a small number were deployed into care homes. In order to ensure that social care has the support it needs in preparation for winter and future outbreaks, the NHS and social care should continue to work in close partnership at every level. In particular all systems should review their local workforce position with providers and implement arrangements for their areas to increase resilience and capability.

In addition to the returners and young professionals' scheme, there have been some very good examples of programmes developed by local systems across health and care that have increased the supply of nurses and reduced movement.

All systems should review their local workforce position with providers and implement arrangements for their areas to increase resilience and capability. The government's Infection Control Fund can be used to support such initiatives.

In a wider context, the NHS can play a significant role in local economic recovery and improving social and economic outcomes, including reducing inequalities. Health and care systems, in particular, can build on the role of NHS organisations and large social care employers as anchor institutions, to bring those furthest from employment into meaningful employment and to target recruitment, volunteering and apprenticeship opportunities in areas of greater deprivation, for example.

Workforce planning and transformation

- **Systems planning:** Systems must strengthen their approach to workforce planning to use the skills of our people and teams more effectively and efficiently. This includes playing a greater role in planning, fully integrating this with service and clinical strategies and financial plans, and reviewing these plans in-year in response to changes to demand or services. In developing their plans, systems may find it helpful to consider key workforce planning questions.

- **Support for planning:** Systems should work with HEE and NHS England and NHS Improvement regional teams to further develop competency-based workforce modelling and planning for the remainder of 2020/21, including assessing any existing skill gap and agreeing system-wide actions to address it. During 2020/21, HEE will develop an online package to train systems in using the HEE Star model for workforce transformation. This training will equip workforce leads with the capability to lead complex workforce conversations across care pathways, provider organisations and systems.

- **Data collection:** In 2020/21, NHS England and NHS Improvement and HEE will begin urgent work to improve workforce data collection at employer, system and national level.

- **Transformation tools:** In 2020/21, NHS England and NHS Improvement and HEE will refresh tools to support workforce planning and transformation and establish communities of practice for workforce analytics and modelling, workforce design and workforce planning.

Recruiting and deploying staff across organisations and geographies

- **Recruitment:** Systems should make better use of routes into NHS careers (including volunteering, apprenticeships and direct-entry clinical roles) as well as supporting recruitment into non-clinical roles. Systems should also make much greater use of secondments and rotational roles across primary and secondary care to improve integration and retention.

- **Recruiting across communities:** Systems should actively work alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers.

- **Staff banks:** When recruiting temporary staff, systems, trusts and primary care networks should prioritise the use of bank staff before more expensive agency and locum options and reducing the use of 'off framework' agency shifts during 2020/21. Through its Bank Programme, NHS England and NHS Improvement will work with employers and systems to improve existing staff banks' performance on fill rates and staff experience, aiming by 31 March 2021 to increase the number of staff registered with banks.

- **Movement across organisations:** Systems should develop workforce sharing agreements locally, to enable rapid deployment of our people across localities where appropriate or where possible. NHS England and NHS Improvement has developed guidelines to make it easier, enabling the sharing of information such as HR records and statutory and mandatory training.

- **Digital staff passport:** Systems are supporting the trial of the COVID-19 digital staff passport during winter 2020, which simplifies the high volume of temporary staff movement between NHS organisations, saves time by providing a verified record of identity and employment, and allows colleagues to carry their credentials and professional registration on their smartphone.

LAURA ARROWSMITH

COVID-19 Ward Cleaner, Leighton Hospital, Crewe.

6 Supporting our NHS people for the long term

This plan sets out the areas where everyone in the NHS has a part to play in making a difference for the rest of 2020/21. The starting point will differ across parts of the NHS. But all of our actions need to keep behaviour and culture change at their heart – and there is a strong appetite and need to do things differently.

The Interim People Plan was published in June 2019 when the world, and healthcare, looked very different. However, the central themes – more staff, working differently, in a compassionate and inclusive culture – are just as valid in today's NHS.

We were already starting to see change emerging. But the arrival of COVID-19 acted as a springboard, bringing about an incredible scale and pace of transformation. It also brought the work that everyone does in the NHS into the spotlight. Key workers have rightly been recognised for the enormous contribution that they make.

The NHS must build on this momentum and continue to transform. The best way to deliver change rapidly is to mobilise a 'movement for improvement'. To create this, health and care systems across the NHS should engage with their people and employers to develop system people plans that deliver the ambitions set out in this document, recognising that the uncertainty we all face makes this an even more pressing priority. These plans should align with system implementation plans being developed for the next phase of the response to COVID-19.

More work is still needed to increase the the number of people in key specialty areas, and to reform the way we educate and train clinicians for a more flexible modern NHS. Further action for 2021/22 and beyond is expected to be set out later in the year, once funding arrangements for future years have been confirmed by the government.

We must sustain our focus and energy to meet the pace and scale of the challenge that is still to come through the next phase of the response to COVID-19 and through the winter period. The NHS and its partners have shown grit and determination over the last few months. We must now continue to support each other, as we do our best for our patients.

Stay involved in the conversation

Hearing your feedback is crucial. NHS England and NHS Improvement and HEE will continue a programme of engagement, with webinars, discussion groups and roundtables running throughout the rest of this year and beyond on the topics covered in this plan. Find out more about how to get involved at: **www.england.nhs.uk/ournhspeople**

St Thomas' Hospital was one of the NHS and landmark buildings to be lit up in blue on 5 July to mark the NHS' birthday.

If you would like this information in an alternative format, please contact nhsi.peopleplancomms@nhs.net

www.england.nhs.uk/ournhspeople

NHS Employers
Part of the NHS Confederation

PEOPLE PLAN ACTIONS

Actions for employers, systems and national bodies in the NHS People Plan 2020/21

In each area of the NHS People Plan, the document sets out actions for employers, national bodies and systems.

Please find below a summary of these actions:

HEALTH AND WELLBEING

	Action	Who	Timeline (where provided)
1	Put in place effective infection prevention and control procedures.	Employers	
2	Ensure all staff have access to appropriate personal protective equipment (PPE) and are trained to use it.	Employers	
3	All frontline healthcare workers should have a vaccine provided by their employer.	Employers	
4	Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.	Employers	
5	Ensure people working from home can do safely and have support to do so, including having the equipment they need.	Employers	
6	Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way.	Employers	
7	Prevent and tackle bullying, harassment and abuse against staff, and a create a culture of civility and respect.	Employers	

8	Prevent and control violence in the workplace – in line with existing legislation.	Employers	
9	NHS violence reduction standard to be launched.	NHS England and NHS Improvement	December 2020
10	Appoint a wellbeing guardian.	Employers	
11	Continue to give staff free car parking at their place of work.	Employers	At least the duration of the pandemic
12	Support staff to use other modes of transport and identify a cycle-to-work lead.	Employers	
13	Ensure staff have safe rest spaces to manage and process the physical and psychological demands of the work.	Employers	
14	Ensure that all staff have access to psychological support.	Employers	
15	Continue to provide and evaluate the national health and wellbeing programme.	NHS England and NHS Improvement	
16	Identify and proactively support staff when they go off sick and support their return to work.	Employers	
17	Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day.	Employers	
18	Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout.	Employers	

19	Every member of NHS staff should have a health and wellbeing conversation.	Employers	From August 2020
20	All new starters should have a health and wellbeing induction.	Employers	From October 2020
21	Provide a toolkit on civility and respect for all employers.	NHS England and NHS Improvement	March 2021
22	Pilot an approach to improving staff metal health by establishing resilience hubs.	NHS England and NHS Improvement	
23	Pilot improved occupational health support in line with the SEQOHS standard.	NHS England and NHS Improvement	

FLEXIBLE WORKING

	Action	**Who**	**Timeline (where provided)**
1	Be open to all clinical and non-clinical permanent roles being flexible.	Employers	
2	All job roles across NHS England and NHS Improvement and HEE will be advertised as being available for flexible working patterns.	NHS England and NHS Improvement	January 2020
3	Develop guidance to support employers.	NHS England and NHS Improvement	September 2020

4	Cover flexible working in standard induction conversations for new starters and in annual appraisals.	Employers	
5	Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade.	Employers	
6	Board members must give flexible working their focus and support.	Employers	
7	Add a key performance indicator on the percentage of roles advertised as flexible at the point of advertising to the oversight and performance frameworks.	NHS England and NHS Improvement	
8	Support organisations to continue the implementation and effective use of e-rostering systems.	NHS England and NHS Improvement	
9	Roll out the new working carers passport to support people with caring responsibilities.	Employers	
10	Work with professional bodies to apply the same principles for flexible working in primary care.	NHS England and NHS Improvement	
11	Continue to increase the flexibility of training for junior doctors.	Health Education England	

EQUALITY AND DIVERSITY

	Action	Who	Timeline (where provided)
1	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.	Employers	By October 2020
2	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.	Employers	From September 2020
3	Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce.	Employers	
4	51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes.	Employers	By the end of 2020
5	Support organisations to achieve the above goal, including establishing robust decision-tree checklists for managers, post-action audits on disciplinary decisions, and pre-formal action checks.	NHS England and NHS Improvement	From September 2020
6	Refresh the evidence base for action, to ensure senior leadership represents the diversity of the NHS, spanning all protected characteristics.	NHS England and NHS Improvement	From September 2020

CULTURE AND LEADERSHIP

	Action	Who	Timeline (where provided)
1	Work with the National Guardians office to support leaders and managers to foster a listening, speaking up culture.	NHS England and NHS Improvement	With immediate effect
2	Promote and encourage employers to complete the free online just and learning culture training and accredited learning packages, and take demonstrable action to model these leadership behaviours.	NHS England and NHS Improvement and Health Education England	With immediate effect
3	Provide refreshed support for leaders in response to the current operating environment.	NHS England and NHS Improvement	From September 2020
4	Work with the Faculty of Medical Leadership and Management to expand the number of placements available for talented clinical leaders each year.	NHS England and NHS Improvement	By March 2021
5	Update the talent management process to make sure there is greater prioritisation and consistency of diversity in talent being considered for director, executive senior manager, chair and board roles.	NHS England and NHS Improvement	By December 2020
6	Launch an updated and expanded free online training material for all NHS line managers, and a management apprenticeship pathway for those who want to progress.	NHS England and NHS Improvement	By January 2021
7	All central NHS leadership programmes to be available in digital format and accessible to all.	NHS England and NHS Improvement, Health Education England	By April 2021

8	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.	All NHS organisations	By December 2021
9	Publish resources, guides and tools to help leaders and individuals have productive conversations about race, and to support each other to make tangible progress on equality, diversity and inclusion for all staff.	NHS England and NHS Improvement	From October 2020
10	Publish competency frameworks for every board-level position in NHS provider and commissioning organisations.	NHS England and NHS Improvement	By March 2021
11	Place increasing emphasis on whether organisations have made real and measurable progress on equality, diversity and inclusion, as part of the well-led assessment.	Care Quality Commission	Throughout 2020/21
12	Launch a joint training programme for Freedom to Speak Up Guardians and WRES Experts, and recruit more BAME staff to Freedom to Speak Up Guardian roles.	NHS England and NHS Improvement	By March 2021
13	Publish a consultation on a set of competency frameworks for board positions in NHS provider and commissioning organisations.	NHS England and NHS Improvement	During October 2020
14	Finalise a response to the Kark review.	NHS England and NHS Improvement	No timeframe provided
15	Launch a new NHS leadership observatory highlighting areas of best practice globally, commissioning research, and translating learning into practical advice and support for NHS leaders.	NHS England and NHS Improvement	By March 2021

NEW WAYS OF DELIVERING CARE

	Action	Who	Timeline (where provided)
1	Use guidance on safely redeploying existing staff and deploying returning staff, developed in response to COVID-19 by NHSEI and key partners, alongside the existing tool to support a structured approach to ongoing workforce transformation.	Employers	
2	Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression.	Employers	
3	Use HEE's e-Learning for Healthcare programme and a new online Learning Hub, which was launched to support learning during COVID-19.	Employers and organisations	
4	Work with the medical Royal Colleges and regulators to ensure that competencies gained by medical trainees while working in other roles during COVID-19 can count towards training.	Health Education England	
5	Develop the educational offer for generalist training and work with local systems to develop the leadership and infrastructure required to deliver it.	Health Education England	During 2020/21
6	Support the expansion of multidisciplinary teams in primary care.	Health Education England	End of 2020/21

GROWING THE WORKFORCE

	Action	Who	Timeline (where provided)
1	Enabling up to 300 peer-support workers to join the mental health workforce and expanding education and training posts for the future workforce.	Health Education England	2020/21
2	Increasing the number of training places for clinical psychology and child and adolescent psychotherapy by 25 per cent (with 734 starting training in 2020/21).	Health Education England	
3	Investing in measures to expand psychiatry, starting with an additional 17 core psychiatry training programmes in 2020/21 in areas where it is hard to recruit, and the development of bespoke return to practice and preceptorship programmes for mental health nursing.	Health Education England	
4	Prioritise the training of 400 clinical endoscopists and 450 reporting radiographers.	Health Education England	2021
5	Training grants are being offered for 350 nurses to become cancer nurse specialists and chemotherapy nurses.	Health Education England	2021
6	Training 58 biomedical scientists, developing an advanced clinical practice qualification in oncology, and extending cancer support-worker training.	Health Education England	2021
7	HEE is funding a further 400 entrants to advanced clinical practice training.	Health Education England	2020/21
8	Investing in an extra 250 foundation year 2 posts, to enable the doctors filling them to grow the pipeline into psychiatry,	Health Education England	2020/21

	general practice and other priority areas, notably cancer, including clinical radiology, oncology and histopathology.		
9	Increase of over 5,000 undergraduate places from September 2020 in nursing, midwifery, allied health professions, and dental therapy and hygienist courses.	Health Education England	2020/21
10	Employers should fully integrate education and training into their plans to rebuild and restart clinical services, releasing the time of educators and supervisors; supporting expansion of clinical placement capacity during the remainder of 2020/21; and providing an increased focus on support for students and trainees, particularly those deployed during the pandemic response.	Employers	2020/21
11	For medical trainees, employers should ensure that training in procedure-based competencies is restored as services resume and are redesigned to sustain the pipeline of new consultants in hospital specialties.	Employers	2020/21
12	Ensure people have access to continuing professional development, supportive supervision and protected time for training.	Employers	2020/21
13	Establish a £10m fund for nurses, midwives and allied health professionals to drive increased placement capacity and the development of technology-enhanced clinical placements.	Health Education England	
14	HEE to further develop its e-learning materials, including simulation, building on the offer provided in response to COVID-19.	Health Education England	2020/21

15	Start delivering a pre-registration blended learning nursing degree programme. The programme aims to increase the appeal of a nursing career by widening access and providing a more flexible approach to learning, using current and emerging innovative and immersive technologies.	Health Education England /Universities	From Jan 2021
16	HEE to pursue this blended learning model for entry to other professions.	Health Education England	From Jan 2021

RECRUITMENT

	Action	**Who**	**Timeline (where provided)**
1	Increase recruitment to roles such as clinical support workers, highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles.	Employers	
2	Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.	Employers	
3	Develop lead-recruiter and system-level models of international recruitment, which will improve support to new starters as well as being more efficient and better value for money.	Systems	
4	Primary care networks to recruit additional roles, funded by the additional roles reimbursement scheme, which will fund 26,000 additional staff until 2023/24.	Systems	Immediate

5	Increase ethical international recruitment and build partnerships with new countries, making sure this brings benefit for the person and their country, as well as the NHS.	NHS England and NHS Improvement and Health Education England	
6	HEE will pilot English language programmes – including computer-based tests, across different regions as well as offering English language training.	Health Education England	2020/21
7	Establish a new international marketing campaign to promote the NHS as an employer of choice for international health workers.	NHS England and NHS Improvement	2020/21
8	Encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response.	Employers and systems	2020/21
9	Continue to work with professional regulators to support returners who wish to continue working in the NHS to move off the temporary professional register and onto the permanent register.	NHS England and NHS Improvement and Health Education England	2020/21

RETAINING STAFF

	Action	Who	Timeline (where provided)
1	Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.	Employers	
2	Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.	Employers	
3	Ensure staff are aware of the increase in the annual allowance pensions tax threshold.	Employers	
4	Make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities.	Employers	
5	Explore the development of a return to practice scheme for other doctors in the remainder of 2020/21, creating a route from temporary professional registration back to full registration.	Health Education England	2020/21
6	Develop an online package to train systems in using the HEE star model for workforce transformation.	Health Education England	2020/21
7	Improve workforce data collection at employer, system and national level.	Health Education England	2020/21
8	Support the GP workforce through full use of the GP retention initiatives outlined in the GP contract, which will be launched in summer 2020.	Systems	

9	Strengthen the approach to workforce planning to use the skills of our people and teams more effectively and efficiently.	Systems	
10	Work with HEE and NHSEI regional teams to further develop competency-based workforce modelling and planning for the remainder of 2020/21, including assessing any existing skill gap and agreeing system-wide actions to address it.	Systems	2020/21

RECRUITMENT AND DEPLOYMENT ACROSS SYSTEMS

	Action	**Who**	**Timeline (where provided)**
1	Actively work alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers.	Systems	
2	Make better use of routes into NHS careers (including volunteering, apprenticeships and direct-entry clinical roles) as well as supporting recruitment into non-clinical roles.	Systems	By March 2021
3	Develop workforce sharing agreements locally, to enable rapid deployment of our people across localities.	Systems	
4	When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reducing the use of 'off framework' agency shifts during 2020/21.	Systems, employer and primary care networks	2020/21
5	Work with employers and systems to improve existing staff banks' performance on fill rates and staff experience.	NHS England and NHS Improvement	

NHS People Plan 2020/21
Audio Version link

https://digital.leadershipacademy.nhs.uk/people-plan-audio/