House of Commons

Health and Social Care Committee

Delivering core NHS and care services during the pandemic and beyond: Government Response to the Committee's Second Report of Session 2019–21

Second Special Report of Session 2019–21

Ordered by the House of Commons to be printed 12 January 2021

HC 1149
Published on 15 January 2021
by authority of the House of Commons

Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health & Social Care.

Current membership

Rt Hon Jeremy Hunt MP *(Conservative, South West Surrey)* (Chair)

Paul Bristow MP *(Conservative, Peterborough)*

Rosie Cooper MP *(Labour, West Lancashire)*

Dr James Davies MP *(Conservative, Vale of Clwyd)*

Dr Luke Evans MP *(Conservative, Bosworth)*

Neale Hanvey MP *(Scottish National Party, Kirkcaldy and Cowdenbeath)*

Barbara Keeley MP *(Labour, Worsley and Eccles South)*

Taiwo Owatemi MP *(Labour, Coventry North West)*

Sarah Owen MP *(Labour, Luton North)*

Dean Russell MP *(Conservative, Watford)*

Laura Trott MP *(Conservative, Sevenoaks)*

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/hsccom and in print by Order of the House.

Committee staff

The current staff of the Committee are Jasmine Chingono (Clinical Fellow), Laura Daniels (Senior Committee Specialist), Matt Case (Committee Specialist), James Davies (Clerk), Gina Degtyareva (Media Officer), Previn Desai (Second Clerk), Sandy Gill (Committee Operations Officer), Bethan Harding (Assistant Clerk), James McQuade (Committee Operations Manager), Kandirose Payne-Messias (Committee Support Apprentice), and Anne Peacock (Senior Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hsccom@parliament.uk.

Second Special Report

The Committee published its Second Report of Session 2019–21, *Delivering core NHS and care services during the pandemic and beyond* (HC 320), on 1 October 2020. The Government response was received on 24 December 2020 and is appended to this report.

Appendix 1: Government Response

Waiting times and managing the backlog of appointments

> We recommend that the Department of Health & Social Care and NHSE/I provide an update on what steps they have, individually and collectively, taken and are planning to take to quantify and address the overall impact of the pandemic on waiting times, the backlog of appointments and pent-up, and as yet unknown and unmet patient demand for all health services, specifically across cancer treatments, mental health services, dentistry services, GP services and elective surgery. We also ask the Department and NHSE/I to provide a comprehensive update on what steps are being taken and what steps will be taken in the future to manage the overall level of demand across health services. We request this information by the end of October 2020.

Elective care

For elective care, the official statistics show that waiting times have been impacted by the pandemic, from a combination of enhanced IPC measures, and patients choosing to defer their care. The pace of recovery of elective care since the first wave of Covid-19 inpatients means that the total number of people waiting over 18 weeks has fallen month on month since July. Total cancer treatments are now back at or above the levels seen in 2019. However, the number of people waiting over 52 weeks has been rising, which is why additional funding for elective catchup will focus in part on these waits.

The waiting list in October 2020 was 4.5m, slightly lower than the same time last year. Through the 'phase 3' guidance issued at the end of July 2020, focus has been on increasing elective activity by accelerating the return of non-Covid health services to as near-normal levels as possible whilst also preparing for winter demand pressures. Hospitals are now carrying out more than a million routine appointments and operations per week, with around three times the levels of elective patients admitted to hospital than in April.

The NHS has been working with Royal Colleges to ensure clinical processes to prioritise the waiting list according to clinical need and length of waiting time. Patients should be part of a shared decision-making discussion around their care.

In responding to the pandemic, trusts have been working collaboratively to sustain access for patients, and this has been supported by the development of more "hub" working models to support elective recovery.

This "Adopt & Adapt" approach uses the following key components:

- **Workforce:** Prioritising workforce capacity to support challenged services, in much the same way that staff were deployed to critical care during Phase 1.
- **Best IPC Practices:** including COVID-19/Non-COVID-19 pathways; self-isolation guidance; testing; PPE; cleaning and building guidelines relevant to the service in question.
- **Additional Capacity & Facilities:** Opportunities to utilise NHS facilities by sharing waiting lists; independent sector capacity and identify temporary facilities.

The £1bn allocated through the Spending Review for the 2021/22 financial year will support the NHS in tackling the elective backlog and support hospitals to cut long waits for treatment by carrying up to one million extra checks, scans and additional operations or procedures.

Through its COVID-19 recovery and existing planning processes, DHSC and NHSE/I are currently working (with NHS organisations) to agree how this funding will be spent in order to achieve maximum value and ensure the clinical needs of patients are best met.

Primary care

Impact of the pandemic

Monthly appointment numbers continue to rise since April and overtook pre-Covid-19 peak in September and October. An estimated 282.5 million appointments were booked across all GP practices in England in the twelve months up to October 2020.

The Department and NHSE/I continue to work with general practices to help them meet demand safely and reassure patients that they should seek care when they need it. Steps being taken include:

- a new £150 million General Practice Covid Capacity Expansion Fund has been made available up until the end of March 2021. This will support seven priority goals including expanding GP capacity, supporting clinically extremely vulnerable patients, continuing to tackle the backlog of some routine appointments with a particular focus on learning disability health checks, and supporting the establishment of Oximetry@home.
- helping general practice adapt at pace to offer more remote care so that patients could continue to access GP services safely, by deploying laptops and headsets for use in primary care and accelerating the roll out of online video consultation capability.
- refocusing the Quality and Outcomes Framework to support local outbreak management.
- NHSE/I launched the Health at Home campaign which includes information and videos for patients on how to access GP services, including how to have an

online and video consultation.

- DHSC and NHSE/I are working to maximise workforce capacity through continued deployment and recruitment of the GP workforce and increasing the participation of the existing workforce including through local GP initiatives.
- through national and regional campaigns, the NHS continues to emphasise that general practice is open and to urge the public to come forward with any health concerns they have. The NHS winter communication campaign includes a general practice component, encouraging patients to see their GP for example to get possible cancer symptoms checked.
- continued work on improving recording of ethnicity and other protected data in patient records; helping to ensure more comprehensive data is available on health inequalities to better support public health planning and targeted interventions at a local level.

We recognise that on top of the usual winter pressures and the commitment to recover routine activity, general practice is also delivering an expanded flu programme and playing an integral part in the delivery of Covid vaccination. We will continue to monitor the delivery of GP services throughout winter and support practices to ensure that patients receive the care they need.

Mental Health

In relation to mental health services, we recognise this is a very difficult time for people, and the immense strain that the pandemic is placing on everyone's lives.

While mental health referrals dropped during the first wave, these are nearly back to pre-pandemic levels and we would urge anyone who needs help to reach out for it. Mental health trusts have responded rapidly to support people through the pandemic and will continue to do so through winter—mental health services have remained 'open for business' throughout the pandemic, with care often delivered remotely via telephone or video as well as face to face where appropriate.

All mental health trusts have established 24/7 urgent mental health helplines where people experiencing a mental health crisis can access urgent support and advice (ahead of the schedule in the NHS Long Term Plan), and have continued to meet waiting time targets e.g. Improving Access to Psychological Treatment services and early intervention in psychosis waiting times. This is why we have, since March, provided £10.2 million of additional funding to mental health charities to support adults and children, including £6million to the Coronavirus Mental Health Response Fund, led by Mind and the Mental Health Consortia, and £4.2million to mental health charities through the Government's £750million Coronavirus Charities Fund.

We also recognise the pressures the pandemic is having on children and young people. We have invested £8million in our Wellbeing for Education Return programme, which is providing schools and colleges all over England with the knowledge and access to resources they need to support children and young people, teachers and parents. We also remain committed to implementing the core proposals set out in our response to the Green Paper consultation on improving children and young people's mental health provision.

Moving into winter we adapted the national restrictions to support people's wellbeing – we have kept schools, further education colleges and universities open as we know how important this is for children and young people's wellbeing and we have extended the furlough scheme to provide financial security during this time.

To further support people's mental health in the context of a second wave of COVID-19, and the winter months, in November we brought forward our Wellbeing and Mental Health Support Plan setting out the steps we have taken to strengthen the support available for people who are struggling, our commitments to ensure services are there to support those who need it, and the provision in place to keep our frontline workers well. The plan also includes a commitment, backed by £50million, to boost capacity and support good quality discharge for mental health service users from inpatient settings.

In addition, as part of the Spending Review, we announced that the NHS will receive around an additional £500 million next year to address waiting times for mental health services, give more people the mental health support they need, and invest in the NHS workforce.

It remains this government's priority to support people's mental healt—that is why we are investing an additional £2.3billion a year by 23/24 to deliver the most ambitious major expansion and transformation of mental health services ever across England. This growing investment in mental health services will see 345,000 more children and young people and a further 380,000 more adults accessing specialist NHS treatment a year by 2023/24, if they need it.

Dental services

The backlog in dental appointments is a function of the precautions needed to avoid infection through COVID-19. DHSC acknowledges the impact that the coronavirus pandemic has had on the provision of NHS dentistry across the country and is working with the profession to increase the level of service as fast as possible, acknowledging the ongoing social distancing and infection prevention and control requirements.

Guidance has now been published by Public Health England that updates infection prevention control procedures. This includes reduced time to rest a room between patients. Whilst this should allow dentists to see a greater number of patients, dentists will still be seeing significantly fewer patients per day than pre COVID-19.

The Department is in the early stages of exploring how dentistry may be able to use Point of Care testing to increase patient throughput in future, however this is heavily dependent on a number of factors, such as the availability of testing technologies and a full assessment of the impact on risk for patients and staff.

Impact of the pandemic

Immediate changes to services due to the overriding need to limit transmission of COVID-19 at the end of March included:

- deferring routine, non-urgent dental care including orthodontics

- establishing remote urgent care services, providing telephone triage for patients with urgent needs and
- setting up networks of urgent dental care (UDC) sites for face-to-face care where clinically necessary.

On 28 May 2020 we wrote to NHS dental practices setting out the arrangements to restart face to face dental services from 8 June. Since then we have seen practices re opening for face-to-face care. In doing so practices have managed challenges presented by the need for infection prevention control and social distancing in order to minimise infections and the risk presented to staff.

Practices have restructured patient flows, adopted use of extensive PPE, incorporated fallow time to follow aerosol generating procedures in line with IPC guidance, and increased use of remote triage and consultation. These constraints impact on the tempo of clinical care, practice capacity and overall throughput and will remain in place for the foreseeable future.

We are focused on a combination of activities to support practices to maximise throughput and capacity within the current system, protect the staff who work in those practices, and prioritise activity to minimise deterioration in oral health.

We continue to engage with the profession and stakeholders to produce regular guidance supporting providers and commissioners to deliver these aims in the form of regular letters and Standard Operating Procedures.

Maximising capacity

We have seen a rise in dental activity month by month between July and September which is likely to reflect practices refining new procedures to operate more efficiently within current constraints. However, we anticipate this will plateau over time.

We will seek a longer-term contractual position with the BDA which reflects the need to maximise use of current capacity for highest priority patient care whilst recognising the constraints of operating safely in line with current guidance.

Protecting staff

Staff in dental practices need access to high grade PPE to maintain the safety of staff and patients. DHSC has provided access for dental practices to funded PPE via an online portal and we are working to encourage practices to sign up.

We have asked that all dental practices undertake a staff risk assessment and continue to maintain and act on these assessments over time, taking mitigating actions where they are indicated.

Prioritisation of Activity

Our focus remains on addressing oral health needs that may have increased, developed or gone unmet during the initial phase of the pandemic. Practices should continue to restore activity and prioritise care in line with letters and Standard Operating Procedures (SOPs) currently in force. Practices are expected to:

- provide access for urgent care,
- restore care, which was delayed during the initial phase of lockdown,
- prioritise patients who are at highest risk of disease and manage patients who are low risk by adhering to the NICE recall guidance for face to face care, supplemented where necessary through remote consultation and advice
- maintain access for new patients and patients previously cared for by the practice
- deliver appropriate clinical care including treatment involving aerosol generating procedures (AGPs) and will observe the proportions of courses of treatment involving AGPs
- deliver prevention activities that involve the delivery of best practice prevention

The application of this prioritisation approach will be made possible by practices continuing to undertake remote triage in advance of face to face care.

The limited system capacity, and significant backlog of routine work, means that we can expect urgent dental care to make up higher proportion of total activity over coming months than we would have seen pre-pandemic. We will continue to have in place arrangements as required for urgent dental care through UDCs or practices.

Other workforce considerations

Prerana Issar's letter of 03 December 2020 set out a number of positive developments on the NHS workforce in recent years, but we understand that you are seeking in addition aclearer understanding of our supply and demand assumptions and scenarios over a longer strategic timeframe. We will write to the Committee again in the New Year to provide a fuller picture on the ranges of projections for key workforce groups that are informing policy.

Chief Dental Officer's assessment and proposed next steps

4. We recommend that Sara Hurley (Chief Dental Officer for England) sets out her assessment of the challenges facing dentistry services in England, and clarifies what steps will be taken to ensure dentistry services are able to continue to be restored to meet patient demand in the safest possible way whilst also remaining financially sustainable. (Paragraph 68)

The Chief Dental Officer for England's remit extends to clinical policy and does not cover operational delivery or contracting, which sits with the Department of Health & Social Care and the NHS.

This assessment has focussed on the restoration of primary dental care services, this is not to diminish or dismiss the range of issues relating to specialist dental care or access to secondary care. This would be subject to a separate analysis.

The COVID-19 pandemic has undoubtedly challenged the delivery of safe dental care as much as it has proved a challenging time for the dental sector. We asked the dental profession to temporarily cease face-to-face dental care in the interests of public safety. In accepting this significant ask and then tackling the complexities of resuming face to face dental care in the new COVID-19 landscape the dental profession has remained steadfast to the principles of patient care and compassion. In stepping up to the challenges and stepping into new roles and new responsibilities I continue to be extremely proud of our profession's response to the crisis.

The postponement of elective dental care, at the outset of the pandemic, prompted over 18,000 dental professional volunteers to register to support surge capacity whilst others re-orientated their practices and teams to support patients via remote dental consultations. The NHS delivered a national urgent dental care system of remote consultation and has staffed over 600 NHS urgent dental care (UDC) hubs. This collective endeavour has ensured timely access to advice and treatment. The majority of these UDC hubs were set up and run by general dental practitioners and their dental teams. These committed teams of dental professionals have continued to provide contingency access to urgent dental care throughout the Summer and Autumn of 2020.

The vast majority of dental practices are now open for face to face care and they have remained open throughout the re-imposition of national restrictions (04 November – 02 December 2020).

Our clinical focus remains:

- addressing patients' oral health needs that have increased, developed or gone unmet during the initial phase of the pandemic
- ensuring face to face urgent dental care is available
- reviewing interrupted patient care pathways and restarting where appropriate
- ensuring that patients who normally attend the practice are prioritised for care in terms of their risk.

Between June and November, we saw improvements in access with an expanding range of treatments being offered. Approximately 45% of NHS face-to-face dental care is for urgent dental care. Work continues with the British Dental Association (BDA) on future contract mechanisms with the intention of introducing a link to delivery of activity and outcomes.

The plan for the resumption of dental services in England was published in the Transition to Recovery SOP (4 June 2020). A graduated approach to the resumption of the full complement of dental care provision has been shaped by the necessary compliance with national Infection Prevention and Control (IPC) requirements and a full appreciation of

the impacts of the range of patient and workforce protection procedural changes required in every dental practice. The plan acknowledges the demand for care, the need for clinical risk management and the application of a range of evidence-based alternative treatment pathways as well as the necessary agility to respond to a resurgence of COVID-19.

Based on this plan, dental practices have successfully resumed face-to-face dental care, but it is not business as usual. The challenges associated with restoration of dental services are significant and will endure into 2021/22 and beyond. Practices are subject to maintaining social distancing, providing remote consultations ahead of any face to face appointment, implementing necessary IPC guidance and prioritising urgent dental care cases. The quantity and complexity of urgent care presentations and resumption of suspended dental treatment plans is placing demands on clinical time and resources. All these factors will continue to constrain the level of "routine" activity that practices are able to deliver safely, particularly where "fallow-time" is required after aerosol generating procedures.

In assessing future capacity, confidence in process and procedures together with an emerging range of measures offer potential for a reduction in time associated with IPC and delivery of a concomitant increase in practice tempo. The number of patients that can be safely seen in a clinical day will continue to increase.

Personal protective equipment

5. We request an update from the Department of Health & Social Care by the end of November 2020 on what steps are being taken to ensure that there is a consistent and reliable supply of appropriately fitting PPE to all NHS staff in advance of the onset of winter and a potential second wave. (Paragraph 87)

The government is confident that there will be a consistent supply of PPE this winter. Since the initial PPE Plan in April, the UK PPE supply chain has stabilised; there are around 32 billion PPE items on order and there is a strategic stockpile of approximately 4 months' stock of each product category stored in warehouses.

The government is firmly committed to addressing the reported practical difficulties of some PPE to ensure there is appropriately fitting PPE on the frontline. We are committed to understanding user needs and taking appropriate action to incorporate user feedback in PPE provision. Feedback has largely focused on the fit of face masks where an appropriate fit is critical for effective protection.

Resilient FFP3 Supply Chain

DHSC have also developed enhanced supplier relationships partnerships with selected mask manufacturers and suppliers to secure a wider range of FFP3 masks to:

- give NHS trusts and users more choice
- ensure a resilient supply of appropriate fitting masks, suitable for a wider range of face shapes, are getting to the frontline over winter and any second wave.

In September, as part of the strategy to diversify the portfolio of FFP3 masks, DHSC's Face Mask Category Team published a catalogue of 16 different FFP3 masks from 10 manufacturers/ suppliers that are available from the DHSC PPE Programme. Eight models of FFP3 masks are available to the NHS now, with over 30 million units available for distribution. A further eight types will be available in the next two months as part of the UK make strategy. The increased range and diversity of FFP3 masks will make it easier for NHS staff to find a mask that successfully fits and these FFP3 are different shapes and sizes, including a specific model available in small, medium and large sizes.

The masks in the catalogue have been selected because they have resilient high-volume supply chains and meet the highest technical and clinical standards. These supply chains have been established and are managed by DHSC and its partners from Factory to NHS users. The manufacturers are long-established in the PPE industry, have a global scale and have been minimally disrupted by the pandemic.

Additionally, four out of the 10 manufacturers featured in the catalogue are UK-based. This enables us to have a closer relationship with manufacturers and offers more opportunities for the industry to hear directly from the user and involve them in the design and development of products. Some UK manufacturers are already actively ensuring that frontline user experience and preferences are being incorporated into the design and development of products.

DHSC are also ensuring that NHS trusts are receiving their choice of masks, minimising the need for new fit-testing and ensuring staff on the frontline can access masks they have successfully fit-tested to. This system enables each NHS trust to select the percentage of each mask that they'd like to receive, based on which masks best suit their staff. They also have the option to order some specifically for the purpose of fit testing.

Fit testing support to improve personal and clinical choice

Alongside building and managing the resilient supply of high quality FFP3 masks, the government is improving the availability and quality of fit testing in trusts to ensure appropriate PPE is available to NHS staff members. The government has established a Fit Testing Programme for England. This has been set up to support NHS trusts in their fit testing of staff to the new supplies of UK Made FFP3 masks as they become available, and that these fit testers are trained to Health and Safety Executive standards.

User wellbeing

The government is also committed to maximising user comfort and minimising any harm caused by wearing PPE, particularly for those individuals wearing PPE for prolonged periods. Southampton University are undertaking research on PPE use and skin damage including critical thresholds for PPE use, the frequency of breaks required to relieve the skin and the specific regions of the face affected by different FFP3 mask designs.

We are also considering the needs of patients who may be impacted by the PPE worn by staff, for instance those who rely on lip-reading and facial expressions to communicate. DHSC piloted the use of clear face masks and delivered 250,000 masks to NHS and social care providers across the UK as part of the first phase. We are now in the second phase of this pilot; we are gathering further feedback to understand the scale and distribution of

demand to inform future procurement.

Routine testing of all NHS and care staff

6. We accept the advice we have received from many eminent scientists that there is a significant risk that not testing NHS staff routinely could lead to higher levels of nosocomial infections in any second spike. We therefore urge the Government to set out clearly why it is yet to implement weekly testing of all NHS staff. (Paragraph 121)

7. We ask that Professor Whitty sets out to what extent testing capacity has impacted the advice he and his colleagues have provided to the Government on routine testing of NHS staff. We further ask Professor Whitty to clarify whether he has advised the Government to introduce routine testing of all NHS staff in the current virus hotspots and if not why. (Paragraph 123)

8. We recommend that, by the end of October 2020, the Government and NHSE/I set out: i) what current capacity there is for testing all NHS staff, ii) what further capacity (if any) will be required and iii) how long it is likely to take to secure sufficient capacity to offer routine tests to all NHS staff. (Paragraph 125)

Professor Whitty provided a response to recommendation 7 through a separate letter dated 03 November 2020. This letter is attached at **Annex A**.

As set out in the letter from Professor Stephen Powis on 9th November 2020, following further scientific validation of the lateral flow testing modality, and confirmation from Test and Trace that they can now supply the NHS with sufficient test kits, asymptomatic testing of all patient-facing NHS staff is now possible. Full roll is under way, as kits are delivered from Test and Trace.

Long term support for Accident and Emergency departments

12. We recommend that the Department and NHSE/I provide us with an update by the end of November 2020 on the progress of these pilots and other steps that are being taken, in both the short and long-term, to support A&E departments.

The aim of NHS 111 first is to support the triaging of patients before they attend A&E departments and help them access the most appropriate service. All systems have now been nationally assured against a 111 First minimum specification and implementation has continued through December. The minimum specification requires:

- an increased NHS 111 capacity
- the availability of alternative secondary care dispositions to users of NHS 111 services
- the implementation of an ED referral and booking system for users of NHS 111 services
- evaluation and monitoring
- a communications strategy

As part of 111 service improvements, additional 111 capacity has been put in place. We have increased communications to patients to further expand awareness of using NHS 111. A national communications 'Think 111 first' campaign was launched on 1 December with a roll out designed to mitigate sharp increase in activity through a graduated increase in intensity over the first three weeks of the campaign.

There has also been additional capital investment provided to support urgent and emergency care:

- £150m funding 25 major trust schemes
- £300m funding 158 smaller trust schemes

This includes trust schemes to expand waiting areas and increase the number of treatment cubicles, which will support patient flow and infection control measures this winter.

Technology and digital alternatives ("telemedicine")

13. We recommend that NHSE/I and the Department for Health & Social Care set out their assessment of how effective the use of technology and digital alternatives ("telemedicine") has been across all health and care services. As part of this assessment, we ask that both NHSE/I and the Department to clearly set out how they plan to ensure patients' wellbeing is not jeopardised by the risk of being digitally excluded from accessing medical treatment and advice. We also ask that NHSE/I and the Department set out what aspects of telemedicine have worked well, including which new models of service delivery have worked particularly well, and what plans there are (if any) to invest in and support the further use of such technology and new pathways in the health and care system. We request an update on these matters by the end of 2020. We will investigate the use of technology and new pathways in the health and care system more extensively as part of our work in the new year.

In responding to the COVID-19 pandemic, NHSX has been able to support health and social care services in accelerating the uptake of pioneering technologies, to what will be a long- term, transformational effect. We have significant evidence of how widely digital technology has been embraced during the pandemic.

Remote consultations have become embedded within the NHS, through the availability of digital communication tools and the hardware to support them, protecting patients, and clinical capacity. Before COVID-19, survey data suggested only 3% of GP practices had video capability for remote consultations in place; this is now thought to be almost 99%.

This capability is supported by the increased capacity for calls, texts and data for frontline staff on mobiles, broadband to support clinicians working from home, and the electronic sharing of patient records. The NHS has accelerated the use of many digital services at great pace. As a response to the pandemic, NHSX have enabled the use of GP-Connect across the whole primary care estate, easing facilitation for authorised professionals in multiple care settings to directly access GP records, which are held elsewhere, in a safe and secure manner. They have also enabled wider access by authorised professionals to an enriched Summary Care Record with Additional Information which allows a health and care professional to see a patient's medical history and further helps support older patients and those with complex comorbidities.

The public have benefited from the use of the NHS App—we have seen a significant increase in its usage during the pandemic. This demonstrates the appetite amongst the public for using digital to access health information, prescriptions and services.

Public and clinical confidence in digital depends on the security of information. In March NHSX published Information Governance guidance to support health and care staff during the COVID-19 period. This gave the system greater confidence to appropriately use information and tools. In October 2020 NHSX launched an Information Governance Portal, as the home of IG guidance for the health and care system. This provides guidance for IG professionals, front line staff and the public and is supported by the National Data Guardian and the Information Commissioner's Office.

Artificial Intelligence (AI) has demonstrated its potential to enhance the monitoring and diagnosis of patients' conditions. The first round of NHS AI Awards, run by the NHS Accelerated Access Collaborative, in partnership with the NHS AI Lab and the NIHR was announced in September. The awards support technologies from their initial feasibility to deployment, evaluation and potential scalability within the health and care system. The first awards include examples of remote monitoring of patients including Brainomix Ltd e-Stroke Suite which uses AI to interpret stroke brain scans and share information between hospitals in real-time, and Rhythm Technologies Ltd's Zio Service, an ambulatory ECG monitoring service, utilising AI-led processing and analysis for cardiac monitoring.

AI has been further used in the National COVID-19 Chest Imaging Database, a UK database containing X-Ray, CT and MRI images from patients across the country. This is to support a better understanding of the COVID-19 virus and develop AI technology which will enable the best care for patients.

As we shift into a more digitally transformed age, we acknowledge that technological solutions may be less accessible to some groups. Individuals may lack access to a device or may not have the digital skills needed to use them effectively. A direct benefit of using digital platforms is that it frees up the time of healthcare professionals to spend with patients that require face-to-face care, across all health and care settings.

We are supporting service developers to ensure that all services are inclusive. This includes the commissioning of NHS Digital's inclusion Guide; helping healthcare providers and service designers to ensure that digital services are as inclusive as possible, and meet the needs of all sections of their populations. The guidance and templates in the NHS Digital Services Manual, help service developers build digital services that put people first and are; consistent, usable, and accessible. We recently published the digital health technology assessment criteria for health and care (beta). This forms a baseline assessment of the suitability of apps and digital services for use by the NHS, social care or directly by citizens. There are five core assessment areas which digital technologies must adhere to; one of those which developers are assessed on is the accessibility and usability of their product.

NHSX is also working with NHS regions to pilot a digital health champions scheme, with specific communities, to be complemented with an online learning platform providing up-to- date knowledge about core NHS digital products and services.

The NHS Long Term Plan and the DHSC Technology Vision set out a clear expectation that services are digitised to a core level of maturity and are connected through initiatives such

as shared care records. These are then used as a springboard for pathway transformations which improve outcomes, experience and value of care. NHSX will support the health and care system to do this.

In summary, the COVID-19 response has greatly accelerated the use of digital technology, has mainstreamed remote consultations and we are beginning to see a similar effect for remote monitoring. Overall, we are creating greater flexibility and resilience in the workforce, and providing more flexibility in the delivery of services. We have also seen improved decision making and access to information through the better use of data and simplified information governance guidance. We want to embed and extend these changes to support the health and care system's recovery from the pandemic and ongoing resilience.

Letter from Professor Chris Whitty and Professor Stephen Powis to the Committee regarding antigen testing

Department of Health & Social Care

NHS

From the Chief Medical Officer & Chief Scientific Adviser
Professor Chris Whitty CB FMedSci
& the National Medical Director of NHS England
Professor Stephen Powis

7th Floor, 39 Victoria Street
London
SW1H 0EU
chris.whitty@dhsc.gov.uk
www.gov.uk/

Rt Hon. Jeremy Hunt MP
House of Commons
London
SW1A 0AA

03 November 2020

Dear Mr Hunt

Following the publication on September 24th of the Health and Social Care Select Committee report *Delivering core NHS and care services during the pandemic and beyond,* we are writing to update you on covid-19 antigen testing in NHS staff.

We agree with the general principle that regular testing of asymptomatic staff who may have patient contact can be a valuable tool. The value of regular asymptomatic testing to reduce nosocomial transmission is likely to increase as incidence increases, as previously laid out to the Committee. As such, advice has for some time been that asymptomatic testing of healthcare staff should be used during hospital outbreaks and in high incidence settings. In addition, NHS staff have been recruited into the SIREN study and SIREN-associated studies, which we anticipate will provide further evidence on the impact of seropositivity and the optimum frequency of testing.

Testing capacity has of course practically limited what is achievable at any point in time. There are a number of different demands on testing capacity and prioritisation amongst these given capacity at any one time has been complex. These include clinical management (the top priority), testing of symptomatic people, asymptomatic testing in social care settings, asymptomatic testing of elective patients and other uses. DHSC's published testing prioritisation hierarchy, dated 21st September, can be accessed at: https://www.gov.uk/government/publications/allocation-of-covid-19-swab-tests-in-england/allocation-of-covid-19-swab-tests-in-england.

Nevertheless, as testing capacity increases it is becoming possible to extend regular NHS staff testing. On 12 October we announced the commencement of regular staff testing in geographical areas designated by the government as very high risk (tier 3) and this programme has now begun. Testing capacity has been initially provided by the NHS ('pillar 1') and by the government Test & Trace laboratories ('pillar 2').

Furthermore, with the arrival of new testing technologies we are now in a position to expand asymptomatic staff testing further. We have successfully piloted the use of saliva-based testing using Loop Mediated Isothermal Amplification (LAMP). Our aim

is to use this technology, which is less intrusive than swab testing, to become the main form of testing for NHS staff. This technology has already been introduced in several laboratories and our aim is to establish sufficient hubs through NHS Labs and the 'Test and Trace' programme around the country by December 2020 for routine weekly testing of all patient facing clinical staff in the NHS. We attach a report on this technology from the Chief Scientific Officer, Prof. Dame Sue Hill, which we hope will be of interest to the Committee.

We hope this and the attachment are helpful.

Yours sincerely

PROFESSOR CHRIS WHITTY
CHIEF MEDICAL OFFICER AND DHSC CHIEF SCIENTIFIC ADVISER.

PROFESSOR STEPHEN POWIS
NATIONAL MEDICAL DIRECTOR, NHS ENGLAND AND NHS IMPROVEMENT

Appendix 2: Responses to HSCC recommendations: Prerana Issar, NHS Chief People Officer

(1) These recommendations were made on workforce in the report *Delivering core NHS and care services during the pandemic and beyond* publishing 1 October 2020.

(2) Responses to these questions can be found in Sections A to C, below.

A. Recommendation at paragraph 139: Mental and Physical Wellbeing support for Staff, and plan to deal with sustained workplace pressure due to Covid-19

We recommend that NHSE/I set out in detail what further specific steps it would like to take over the coming years to support the mental and physical wellbeing of all staff and a plan to deal with the specific issue of sustained workplace pressure due to the current pandemic and backlog associated with coronavirus. This information should be made available to us in advance of any forthcoming Government spending announcements or by the end of October 2020 (whichever is earlier). in order for us to clarify what NHSE/I's priorities for NHS staff are, and to judge how far the Government's eventual spending commitments enable their implementation.

(3) We know from what staff are telling us, through several channels, that they need support—more now than ever. This is why we are investing in our staff health and wellbeing offer and support for our leaders.

(4) Our People Plan, published in July 2020, sets out the actions we will take during 2020/21, and actions for organisations, teams and individuals, to make the NHS the best place to work. This includes a strong focus on supporting the health and wellbeing of our staff and additional investment so they can provide high-quality care for our patients.

(5) Building on the work from the NHS People Plan and drawing on evidence from major incidents, on 8 April 2020 we launched '**Our NHS People**' health and wellbeing support offer. This national offer complements the local support offers in place, and covers a range of offers to support NHS staff via apps, guides, support helplines and facilitated groups, available via https://people.nhs.uk. We keep the health and wellbeing offer under review by gathering and responding to quantitative and qualitative feedback from staff.

(6) Over the winter we will invest a further £30m (£15m for specialist mental health services, and £15m for enhanced health and wellbeing more broadly) to strengthen the support offer for staff. We will also use this winter to evaluate the impact of this enhanced offer and recommend how it should be adapted and taken forward. It is very likely that ongoing investment on a similar scale will be needed, at least for the next 3 years.

B. Recommendation at paragraph 140: Definition of Workforce Burnout and monitoring/assessing staff wellbeing

We further recommend that NHSE/I should develop a full and comprehensive definition of "workforce burnout" and set out how the wellbeing of all NHS staff is being monitored and assessed. This information should be made available to us by the middle of October 2020, to enable us to scrutinise it in the course of our inquiry into Workforce Burnout and Resilience in the NHS and social care.

(7) In the absence of a clinical definition of burnout, we are guided by the following working definition:

- Burnout is a state of emotional, physical and mental exhaustion caused by excessive and prolonged stress. It occurs when you feel overwhelmed, emotionally drained, and unable to meet constant demands.

(8) Research is currently underway to better understand the factors associated with burnout, with the aim of identifying evidence-based interventions to address it. This work firstly a review of the international literature regarding burnout in nurses, followed by data collection led by Imperial College London. This has been commissioned by our Chief Nursing Officer, Ruth May.

(9) The way staff present and describe their needs will vary, and whilst it is important to be clear about definitions, getting the right help for our staff when they need it is our priority, and in whatever terms they may descibe their need.

(10) We are engaging at national and local levels to monitor and assess wellbeing; for example, through supporting line managers to have individual wellbeing conversations with staff and being better able to identify the signs of stress.

C. Recommendation at paragraph 154: Definition of racism and discrimination and strategy to tackle these issues

The NHS must increase its efforts to all forms of discrimination and racism from in its organisation. We therefore recommend that NHSE/I and the Department for Health & Social Care to set out in detail its strategy to tackle racism and discrimination and to promote diversity in the NHS, including information on targets and deadlines by the end of 2020. We expect full and constructive engagement with NHSE/I and the Department as we further investigate matters relating to diversity and race in the NHS as part of our future work, including our Workforce Burnout and resilience in the NHS and social care inquiry, in which we will review the root causes of these matters (including the difference between correlation and causation relating to coronavirus and excess deaths amongst BAME communities) and potential solutions.

(11) The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity and inclusion in all its forms. Discrimination, violence and bullying have no place.

(12) To ensure the NHS is inclusive, diverse and a place where discrimination, violence and bullying do not occur, the People Plan asks employers to take action on a range of areas:

- Overhauling recruitment and promotion practices to ensure diverse representation of our workforce
- Ensuring that leadership is representative of the overall BAME workforce
- Reducing disproportionality between BAME and white staff int he entry to formal disciplinary procedures
- Ensuring senior leaders are accountable for progress on equality and inclusion
- Strengenthing staff networks and the voices of BAME staff and other seldom heard staff groups
- Health and wellbeing conversations to empower people to reflect on their lived experience and determine what teams can do to make further progress

(13) In order to ensure that employers make progress, NHS England and NHS Improvement will be tracking delivery and supporting systems in a variety of ways. To ensure recruitment and promotion practices are transformed across the whole NHS, we recently published an Inclusive Recruitment Guidance via NHS Employers and have initiated engagement with key stakeholders, including NHS Employers, staff representative groups, to publish an evidence-based guidance on inclusive recruitment and promotion practices.

(14) The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) already tracks progress on representation across all grades by ethnicity and disability, and we will be working with employers on ensuring their recruitment processes impacts representation across protected characteristics. The WRES and WDES 2020 reports are due before the end of the calendar year.

(15) Employers already have clear goals to ensure that, at every level, their workforce is representative of the overall BAME percentage. We will be analysing the 2020 Model Employer data to assess the progress of individual trusts and CCGs against agreed tracjectories. An update report for each trust will be published thereafter. This evaluation will provide necessary insights for calibrating our Model Employer targets. Internally, NHS England and NHS Improvement is setting the standard in this area and has already established a BAME Talent Management Strategy to ensure 19% of roles in all bands are filled by BAME staff by 2025 at the latest.

(16) The disproportionate representation in BAME staff in formal disciplinary processes has reduced from a relative likelihood of 1.22 in 2019 to 1.06 in 2020. This puts us on course to reach our target of 51% of trusts closing the disciplinary gap, by the end of 2020. Compared to 2017, 2352 less white staff and 1022 less BAME staff entered the formal disciplinary process. Compared to 2019, 727 less white staff and 441 less BAME staff entered the formal disciplinary process.

(17) We will go further by establishing a programme of intervention for the trusts making the least progress and reviewing the need for further national advice, building on the Fair Experience For All Guide published in 2019. We have also

begun to look at how the disciplinary gap for the medical and nursing professions and intend to publish medical data via a Medical WRES report by the end of November.

(18) We are committed to educating leaders across the NHS and ensuring they are accountable for progress on equality, diversity and inclusion. National offers include Inclusive Leadership Development Board Offer to help boards understand their role in overseeing and transforming inclusion in their organisations, and an Executive Seminar Series on Racial Justice for Executive Directors to learn about how to tackle racial discrimination. By March 2021 we will publish competency frameworks for every board-level position to reinforce that Chief Executives are ultimately accountable for progress on inclusion, and all Executive Directors must have clear responsibilities and ojectives.

(19) Whilst all staff have a role to play in tackling all forms of discrimination, staff networks have a particularly important role in empowering our people and ensuring their voice is heard. Organisations should be providing dedictated time and resources for our network activity, listening to them, valuing and supporting them. We are currently conducting a full analysis of the status of BAME staff networks across primary and secondary care, and developing clear deadlines on how to ensure the networks are more effective, and how organisations should ensure networks have a role in their governance structues so they influence decision making in their organisations.

(20) Staff networks are also crucial for organisations to hear about the lived experiences of staff. The Chief People Officer has held regular forums with with the networks throughout the pandemic and these will continue. These forums influenced our decision to nationally drive the improvement in risk assessment deployment for BAME staff that led to BAME staff receiving an assessment where mitigating steps were agreed.

(21) The staff networks have also influenced our health and wellbeing offers to staff, and continue to provide dedicated offers of support to cater for staff during the pandemic via Our NHS People website. Furthermore, we are engaging with all staff to understand how well these offers of support meet their needs and we will continue to work with them to develop additional offers of support where we identify gaps. We will be updating our package of Health and Wellbeing support for BAME staff in the new year.

(22) To foster a freedom to speak up culture in the NHS, we are launching a joint training programme for Freedom to Speak Up Guardians and WRES experts following staff demand. This work will be enabled by the commencement of a research project into ethnicity of guardian roles by the National Guardian Office and we will be issuing a new guidance to Trusts on fair and open recruitment to guardian roles by the end of the year.

Appendix 3: Correspondence

Letter from the Chair

12 November 2020

Dear Matt and Sir Simon,

The Health and Social Care Committee published its report on *Delivering core NHS and care services* during the pandemic and beyond on 1 October 2020. The Report made urgent and evidence-based recommendations to ensure that patients, NHS and care staff and the NHS are properly supported in the face of the significant disruption which has been caused by the pandemic.

I am grateful that, following a further exchange of letters between me, on behalf of the Committee, and Professor Chris Whitty and Professor Stephen Powis, the Committee's recommendation that the testing of patient-facing asymptomatic NHS staff has been agreed to.

Beyond this, however, the Committee has not received a response to the recommendations in its *Delivering core NHS and care services* report which had deadlines of the end of October 2020 or earlier. These recommendations relate to five critical policy areas that require urgent attention: **communication issues with patients; waiting times and managing the backlog of appointments; routine testing of all NHS and care staff; NHS and care workforce wellbeing during the pandemic; and future arrangements with the independent sector**. These recommendations are set out in full at the end of this letter.

As we now approach mid-November, I am deeply concerned that responses to those recommendations have not been provided to the Committee, nor has the Committee received any indication, from either the Department or NHS England & Improvement, that there would be such a delay in response. The Committee recognises the significant pressures on both the Government and NHS England & Improvement but the responses to our recommendations are key to understanding what work is currently underway to support the healthcare system during this critical time, and in supporting our on-going inquiries into *Coronavirus: lessons learnt* and *Workforce burnout and resilience in the NHS and social care*.

I would therefore be grateful if you could ensure that substantive responses to the recommendations, which had a deadline of the end of October 2020 or earlier, are provided to the Committee by Monday 16 November 2020.I am happy for the responses to the remaining recommendations in the Delivering core NHS and care services report to be sent to the Committee by the deadlines stated in the report or, if no deadline is provided, by the normal two-month timeframe.

Yours sincerely,

Rt Hon Jeremy Hunt MP

Chair, Health and Social Care Committee

Annex 1: Recommendations with a deadline of October 2020 or earlier; Delivering Core Services During the Pandemic and Beyond Report

Communication issues with patients

Notwithstanding the actions taken to date, we recommend that NHS England & Improvement review, as a matter of priority, the directions given to NHS Trusts about how to communicate with patients about the progress of their treatment and important medical guidance in any future spike or second wave. As part of this review, NHSE/I must ensure that patients are always treated with dignity and compassion. We ask that as part of that review, NHSE/I makes an assessment of its and hospitals' communication with patients—and provide us with an update by the end of October 2020. We also ask, as part of this review, that NHSE/I address how they will communicate to the general population to ensure that the public gets the message that the NHS is open, and that those who have fears of catching COVID-19 in medical settings are not discouraged from accessing medical treatment. (Paragraph 22)

Waiting times and managing the backlog of appointments

We recommend that the Department of Health & Social Care and NHSE/I provide an update on what steps they have, individually and collectively, taken and are planning to take to quantify and address the overall impact of the pandemic on waiting times, the backlog of appointments and pent-up, and as yet unknown and unmet patient demand for all health services, specifically across cancer treatments, mental health services, dentistry services, GP services and elective surgery. We also ask the Department and NHSE/I to provide a comprehensive update on what steps are being taken and what steps will be taken in the future to manage the overall level of demand across health services. We request this information by the end of October 2020. (Paragraph 65)

We also recommend that NHSE/I provides us with a more broader update on what positive innovations or changes have taken place in the NHS during the pandemic, and how it seeks to ensure all the positive changes that have occurred are captured and potentially implemented across the entire NHS. We expect this information by the end of 2020. (Paragraph 66)

Issues facing NHS and care staff: PPE and testing

Routine testing of all NHS and care staff

We accept the advice we have received from many eminent scientists that there is a significant risk that not testing NHS staff routinely could lead to higher levels of nosocomial infections in any second spike. We therefore urge the Government to set out clearly why it is yet to implement weekly testing of all NHS staff. (Paragraph 121)

We recommend that, by the end of October 2020, the Government and NHSE/I set out: i) what current capacity there is for testing all NHS staff, ii) what further capacity (if any) will be required and iii) how long it is likely to take to secure sufficient capacity to offer routine tests to all NHS staff. (Paragraph 125)

Issues facing NHS and care staff: fatigue and "burnout"

NHS and care workforce wellbeing during the pandemic

We recommend that NHSE/I set out in detail what further specific steps it would like to take over the coming years to support the mental and physical wellbeing of all staff and a plan to deal with the specific issue of sustained workplace pressure due to the current pandemic and backlog associated with the coronavirus. This information should be made available to us in advance of any forthcoming Government spending announcements or by the end of October 2020 (whichever is earlier) in order for us to clarify what NHSE/I's priorities for NHS staff are, and to judge how far the Government's eventual spending commitments enable their implementation. (Paragraph 139)

We further recommend that NHSE/I should develop a full and comprehensive definition of "workforce burnout", and set out how the wellbeing of all NHS staff is being monitored and assessed. This information should be made available to us by the middle of October 2020, to enable us to scrutinise it in the course of our inquiry into Workforce Burnout and Resilience in the NHS and social care. (Paragraph 140)

The NHS: Lessons learnt and building for the future

The independent sector

We recommend, in addition to our recommendations in Chapter 2, that the Government and NHSE/I clarify what plans there are to continue to use independent bed capacity and other independent resources as the winter period approaches. We further recommend that the Government and NHSE/I set out i) what the current level of capacity is across all NHS services, ii) what assessment it has made of what additional capacity will be required, in the medium and long term, to ensure the restoration of non-COVID NHS services and iii) what level of capacity it is expecting and planning to retain from the independent sector in the medium and long term. We expect this information by the end of October 2020. (Paragraph 194)

Letter to the Chair

16 December 2020

Dear Jeremy,

Thank you for report on the delivery of health and care services in the face of the ongoing Covid-19 pandemic, and your letter of 12th November.

The NHS has taken huge strides to restore the services that were necessarily suspended whilst we dealt with the initial wave of the pandemic. For example, the latest statistics show that hospitals are carrying out more than a million routine appointments and operations per week, with around three times more elective patients admitted to hospital than in April, and GP appointments are running ahead of this time last year. We continue to carefully monitor progress, mindful of the additional challenges winter demand pressures that are just around the corner and the effects of a second wave of the pandemic that we are already observing. This letter addresses the recommendations of your report and we will provide further updates in due course. However, some of our responses are caveated by the fact that work is ongoing to address an evolving situation and to develop long-term solutions. Again, where we cannot provide full answers now, we will endeavor to do as soon as we are able.

Communication with patients

Notwithstanding the actions taken to date, we recommend that NHS England & Improvement review, as a matter of priority, the directions given to NHS Trusts about how to communicate with patients about the progress of their treatment and important medical guidance in any future spike or second wave. As part of this review, NHSE/I must ensure that patients are always treated with dignity and compassion. We ask that as part of that review, NHSE/I makes an assessment of its and hospitals' communication with patients—and provide us with an update by the end of October 2020. We also ask, as part of this review, that NHSE/I address how they will communicate to the general population to ensure that the public gets the message that the NHS is open, and that those who have fears of catching COVID-19 in medical settings are not discouraged from accessing medical treatment.

The advice to clinicians on all aspects of Covid-19, including the need for communication with patients is updated when required and is publicly available on the NHS website at https://www.england.nhs.uk/coronavirus/.

In addition, NHS England & NHS Improvement in partnership with Public Health England, are running a 'Help Us, Help You' campaign, aimed at encouraging the public to access NHS services. On 5 October, we launched a phase focusing on increasing uptake of the Flu vaccine and on Friday 9 October 2020 we launched a further phase aimed to encourage the public to speak to their GP if they are worried about a symptom that could be cancer. Further phases will aim to encourage pregnant women to attend their regular check-ups and seek advice if they are worried about their baby and direct people with mental health issues to access National Health Service support. This campaign will utilise a wide range of channelsto reach the public throughout the autumn and winter including TV, radio, out of home posters, print, digital and social, alongside tailored content delivered through a range of influencers, community ambassadors and partnerships.

Waiting times and managing the backlog of appointments

We recommend that the Department of Health & Social Care and NHSE/I provide an update on what steps they have, individually and collectively, taken and are planning to take to quantify and address the overall impact of the pandemic on waiting times, the backlog of appointments and pent-up, and as yet unknown and unmet patient demand for all health services, specifically across cancer treatments, mental health services, dentistry services, GP services and elective surgery. We also ask the Department and NHSE/I to provide a comprehensive update on what steps are being taken and what steps will be taken in the future to manage the overall level of demand across health services. We request this information by the end of October 2020. (Paragraph 65)

In September, the NHS met stretch target of carrying out 80 per cent of the planned overnight hospital inpatient procedures which it delivered last year. In addition, by August, hospitals were carrying out more than a million routine appointments and operations per week, with around three times more elective patients admitted to hospital than in April 2020. This activity is supported by an unprecedented deal with the private sector for them to provide capacity to help address demand for non-Covid activity. To further support activity through winter, we have also announced £3bn of extra NHS funding to ensure the retention of the Nightingale hospital surge capacity continue access to independent hospitals capacity to help meet patient demand.

Nearly 200,000 people were referred for cancer checks in September—102% of last September's levels—and over 45,000 people received treatment for cancer in September—almost matching last year's levels. A newly formed Cancer Recovery Taskforce, bringing together experts from across the cancer community, is overseeing the development of the cancer recovery plan, including taking into account any impact of a 'second wave' and review progress against objectives. The Taskforce is chaired by Professor Peter Johnson, the National Clinical Director for Cancer. It forms part of the NHS Cancer Programme governance structure and reports directly to the National Cancer Board. Membership is drawn from across the cancer community (including charities, Royal Colleges, public and patient voice, and other national partners, e.g. HEE, PHE) to coordinate and share expertise and ultimately enable progress towards the successful recovery of cancer services during 2020/21. The Taskforce will focus on:

- Providing expert input into the further development, publication and delivery of a national recovery plan;
- Reviewing progress against objectives monthly, using the key metrics outlined in the recovery plan, and reporting to the National Cancer Board;
- Identifying where there are requirements that are the responsibility of other stakeholders outside of the cancer programme that are needed for the successful recovery of cancer services, providing a dialogue with the wider cancer community on the national delivery plan and the progress on recovery, and;
- Sharing practical suggestions about what the wider cancer community can do to support recovery.

Routine testing of all NHS and care staff

We accept the advice we have received from many eminent scientists that there is a significant risk that not testing NHS staff routinely could lead to higher levels of nosocomial infections in any second spike. We therefore urge the Government to set out clearly why it is yet to implement weekly testing of all NHS staff. (Paragraph 121)

We recommend that, by the end of October 2020, the Government and NHSE/I set out: i) what current capacity there is for testing all NHS staff, ii) what further capacity (if any) will be required and iii) how long it is likely to take to secure sufficient capacity to offer routine tests to all NHS staff.

As set out in the letter from Professor Stephen Powis on 9th November 2020, following further scientific validation of the lateral flow testing modality last week, and confirmation from Test and Trace that they can now supply the NHS with sufficient test kits, asymptomatic testing of all patient-facing NHS staff is now possible. The first 34 trusts are now deploying this technology, benefiting over 250,000 staff, and full roll out should be in place by the end of next week.

Staff will be asked to test themselves at home twice a week with results available before coming into work. Lateral flow devices have a lower specificity and sensitivity than rt qPCR tests. Testing twice weekly helps mitigate the sensitivity considerations, and to mitigate the lower specificity, all positive results will be retested via PCR.

As you know, this builds on the extensive asymptomatic staff testing already occurring in parts of the country with outbreaks—over 70,000 NHS staff have been tested asymptomatically in those areas in recent days.

In addition, as previously notified, NHS trusts will continue to use their own PCR lab capacity for appropriate staff testing, and LAMP saliva testing is being made available to hospitals by Test and Trace in November and December.

NHS and care workforce wellbeing during the pandemic

We recommend that NHSE/I set out in detail what further specific steps it would like to take over the coming years to support the mental and physical wellbeing of all staff and a plan to deal with the specific issue of sustained workplace pressure due to the current pandemic and backlog associated with the coronavirus. This information should be made available to us in advance of any forthcoming Government spending announcements or by the end of October 2020 (whichever is earlier) in order for us to clarify what NHSE/I's priorities for NHS staff are, and to judge how far the Government's eventual spending commitments enable their implementation. (Paragraph 139)

We further recommend that NHSE/I should develop a full and comprehensive definition of "workforce burnout", and set out how the wellbeing of all NHS staff is being monitored and assessed. This information should be made available to us by the middle of October 2020, to enable us to scrutinise it in the course of our inquiry into Workforce Burnout and Resilience in the NHS and social care. (Paragraph 140)

The Chief People Officer will provide a separate answer on these recommendations.

The independent sector

We recommend, in addition to our recommendations in Chapter 2, that the Government and NHSE/I clarify what plans there are to continue to use independent bed capacity and other independent resources as the winter period approaches. We further recommend that the Government and NHSE/I set out i) what the current level of capacity is across all NHS services, ii) what assessment it has made of what additional capacity will be required, in the medium and long term, to ensure the restoration of non-COVID NHS services and iii) what level of capacity it is expecting and planning to retain from the independent sector in the medium and long term. We expect this information by the end of October 2020. (Paragraph 194)

The Department and NHS England and NHS Improvement have worked with the independent sector to secure all appropriate inpatient capacity and other resource across England. A national agreement is in place between NHS England and NHS Improvement (NHSE/I) in collaboration with the Independent Healthcare Providers Network (IHPN) and Independent Sector providers to ensure National Health Service patients benefit from an unprecedented partnership with private hospitals as we battle the COVID-19 outbreak. An unprecedented deal with the independent sector put their 8,000 beds and 20,000 staff at the NHS' disposal.

To maximise total elective activity, NHSEI worked with Independent providers to identify best use of capacity, based on local need. From end of March to June 2020 both equipment and staffing from independent sector providers were deployed by NHS trusts in order to ensure delivery of services for NHS patients. Since June, the use of independent sector sites has been focused on assisting the NHS to restore services and increase elective capacity. Under the agreement, latest figures show that from 30 March until 30 August 2020 over 967,000 NHS patient appointments have taken place within independent facilities.

Regarding future provision of NHS treatment, an Invitation to Tender was issued by NHS England and NHS Improvement to the healthcare market on 16 October 2020. The Framework will operate for up to four years for additional operations and other inpatient and outpatient services, over and above those which can be delivered within current NHS capacity. Services within the scope of the framework will include:

- Inpatient and day services (including full supporting pathology and imaging) and urgent elective care and cancer treatment, and;
- Diagnostic services like MRI and CT scans.

As outlined previously, £3bn of extra NHS funding has also been announced to support the NHS this winter. This funding includes ensuring the retention of the Nightingale hospital surge capacity as well as continued access to independent hospitals capacity to help meet patient demand.

Further decisions on investment in NHS elective services will be taken through the spending review process in the usual way. We are currently working through the implications of the move to a 1-year SR and the Chancellor will announce the outcome in due course.

Yours sincerely,

Rt Hon Matt Hancock MP Secretary of State for Health & Social Care	Sir Simon Stevens NHS Chief Executive

Letter from the Chair

26 November 2020

Dear Matt, Sir Simon and Prerana,

Thank you for your letters of 13 and 16 November 2020[1] in response to my follow-up letter relating to the recommendations in the Committee's *Delivering core NHS and care services* during the pandemic and beyond report which had deadlines of the end of October 2020 or earlier,[2] and my letter of 21 October 2020 relating to NHS workforce projections.[3]

The responses to the recommendations set out in the Committee's Delivering core NHS and care services report were helpful in clarifying what work is currently taking place to support patients and the NHS. In particular, I am pleased to hear about the on-going work that the Department and NHSE/I are doing to test asymptomatic patient-facing NHS staff and secure further resources from the independent sector to support NHS capacity. The Chief People Officer's letter also helpfully provides a definition of "workforce burnout" that is guiding NHSE/I's work. However, I am disappointed that several key recommendations have been either ignored or inadequately answered. These recommendations relate to: **waiting times and managing the backlog of appointments; NHS and care workforce wellbeing during the pandemic; and support for BAME NHS staff members**. In addition to this, does not address many of the points I raised in my original letter relating to NHS workforce projections.

1. Waiting times and managing the backlog of appointments

Although the joint response provides information on what progress is being made to restore cancer services and the levels of NHS productivity more generally, the joint response does not address the following parts of the recommendation:

- What assessment the Department and NHSE/I have taken to **quantify** the overall impact of the pandemic on waiting times, the backlog of appointments and as of yet unmet demand; and
- What specific steps the Department and NHSE/I are taking to restore **mental health services, dentistry services, GP services** and **elective surgery.**[4]

The Committee welcomes the funding announcements for the NHS made as part of the Spending Review. However, without the backlog of appointments and pent-up demand for NHS medical being clearly quantified, it remains unclear to what extent, if at all, this additional financial investment will be sufficient in supporting the resumption of non-COVID services. I reiterate the Committee's recommendation and ask for this

1 Letter and attachment from Prerana Issar (Chief People Officer, NHSE/I) to Rt Hon Jeremy Hunt MP (Chair, Health & Social Care Committee), 13 November 2020; and Joint letter from Rt Hon Matt Hancock (Secretary of State for Health & Social Care) and Sir Simon Stevens (Chief Executive, NHSE/I) to Rt Hon Jeremy Hunt MP (Chair, Health & Social Care Committee), 16 November 2020.

2 Letter from Rt Hon Jeremy Hunt MP (Chair, Health & Social Care Committee) to Rt Hon Matt Hancock(Secretary of State for Health & Social Care) and Sir Simon Stevens (Chief Executive, NHSE/I), 12 November 2020

3 Letter from Rt Hon Jeremy Hunt MP (Chair, Health & Social Care Committee) to Prerana Issar (Chief People Officer, NHSE/I) on NHS workforce, 21 October 2020

4 Health & Social Care Committee, *Delivering core NHS and care services during the pandemic and beyond* [report], paragraph 65, 1 October 2020, HC 320

information, particularly as it will be central to the Committee's future work in ensuring that patients, NHS staff and the NHS are properly supported in the face of the significant disruption which has been caused by the pandemic.

2. NHS and care workforce wellbeing during the pandemic

The Chief People Officer's response to the recommendation relating to NHS wellbeing during the pandemic is unsatisfactory. The response primarily refers to the 'Our NHS People' health and wellbeing support offer which was launched on **8 April 2020**. The Committee's report was published on **1 October 2020** and had considered this and other initiatives which had already been announced by NHSE/I. The Committee welcomes the Chief People Officer's confirmation that a further investment of £30m will be used to support staff but it still remains unclear how this money will be spent and why. It is frustrating that, in response to the Committee asking for information on what "**further specific steps**" NHSE/I "would like to take **over the coming years** to support the mental and physical wellbeing of all NHS staff",[5] the Chief People Officer's has provided limited and vague information.

Furthermore, the Committee's recommendation had asked for this information in order to help it "clarify what NHSE/I's priorities for NHS staff are, and to judge how far the Government's eventual spending commitments enable their implementation".[6] It is regrettable that the Committee did not receive this information at the appropriate time.

I would be grateful if further full and substantial information can be provided on:

- What **specific steps** are NHSE/I taking and planning to take **over the next five years** to support the mental and physical wellbeing of all NHS staff and in particular what specific steps are being taken to address issue of sustained workplace pressure due to the current pandemic and backlog associated with the coronavirus;

- How and when the further investment of £30m will be spent (i.e. on what specific measures and initiatives), and clarification on what assessment has been made of how this money will be spent.

This information will be key to the Committee's on-going *workforce burnout and resilience in the NHS and social care* inquiry.[7]

3. Support for BAME NHS staff members

The Chief People Officer's response helpfully sets out what initiatives are in place to tackle discrimination and promote diversity in the NHS. It is concerning, however, that the

As part of its recommendation on supporting BAME NHS staff members, the Committee asked "NHSE/I provide a full and comprehensive definition of the "racism and discrimination" that it seeks to eradicate from the NHS."[8] It is deeply concerning

5 Health & Social Care Committee, *Delivering core NHS and care services during the pandemic and beyond* [report], paragraph 139, 1 October 2020, HC 320

6 Ibid

7 Health & Social Care Committee, *Workforce burnout and resilience in the NHS and social care*, inquiry, HC703

8 Health & Social Care Committee, *Delivering core NHS and care services during the pandemic and beyond* [report], paragraph 154, 1 October 2020, HC 320

that the Chief People Officer's response fails to offer such a definition, particularly as the Committee states in its report that "expects full and constructive engagement with NHSE/I and the Department" as it seeks to further investigate the support on offer to BAME NHS staff.[9] Without such a definition, it is unclear what types of discrimination may be prevalent in the NHS, how NHSE/I is seeking to address such issues and whether NHSE/I's efforts have been effective.

I would like to reiterate the Committee's recommendation and **ask for NHSE/I to provide a full and comprehensive definition of the "racism and discrimination" that it seeks to eradicate from the NHS**. This information could be assessed as part of the Committee's on-going inquiries into *Coronavirus: lessons learnt*[10] and *Workforce burnout and resilience in the NHS and social care*[11] with future sessions dedicated to addressing policy matters from the perspective of BAME NHS staff members.

I would be grateful if substantive responses to the recommendations which have not be adequately addressed, as set out above, are provided to the Committee as part of the Department and NHSE/I's wider response to the report. The Committee expects to receive this wider response by the start of December 2020 in accordance with the normal two-month timeframe.

4. Prerana Issar: NHS Workforce

Prerana—following your oral evidence to the Committee's session on *Workforce burnout and resilience in the NHS and social care* on 20 October 2020,[12] I wrote to you to set out the urgency with which 10 year workforce projections for the NHS are required.[13]

We know that the seven years of training required for new doctors necessitates a significant time lag between implementation of policy and deployment of staff. If detailed workforce plans are further delayed, we risk a situation whereby no additional doctors will have completed their training within the lifespan of the NHS 10 year plan. As I wrote in October, this would make a mockery of the original intention to have a 10 year workforce plan to sit alongside the NHS 10 year plan.

- While your letter did clarify the work that is going on regarding workforce, especially modelling in light of COVID-19, the letter failed to address a number of the specific requests for information I set out in my letter. These are:
- Confirmation that workforce numbers would be published after the Spending Review, and would be independent forecasts of the workforce numbers needed over the next 10 years, broken down by specialty and skillset
- Confirmation that the change to a one year spending review would not delay the publication of your 10 year workforce projections
- Confirmation of the date by which the Committee would be able to scrutinise

9 Ibid

10 Health & Social Care Committee and Science & Technology Committee, *Coronavirus: lessons learnt*, joint inquiry, HC 877

11 Health & Social Care Committee, *Workforce burnout and resilience in the NHS and social care*, inquiry, HC 703

12 Health & Social Care Committee, *Workforce burnout and resilience in the NHS and social care: oral evidence* - 20 October 2020, HC 703

13 Letter from Rt Hon Jeremy Hunt MP (Chair, Health & Social Care Committee) to Prerana Issar (Chief People Officer, NHSE/I) on NHS workforce, 21 October 2020

the modelling and the number of professionals NHSE/I estimate will be required to deliver the 10 year Long Term Plan.

I am disappointed that these questions have not been directly addressed, particularly in light of the urgency I described and the limitations this places on the Committee in providing effective and fully informed recommendations. **I would therefore be grateful if you could ensure that substantive responses to the points listed above are provided by Thursday 3 December 2020.**

The Committee recognises the significant pressures on both the Government and NHS England & Improvement but the responses to our recommendations are key to understanding what work is currently underway to support the healthcare system during this critical time, and in supporting our on-going inquiries.

Yours,

Rt Hon Jeremy Hunt MP

Chair, Health and Social Care Committee

Letter from Simon Stevens

03 December 2020

Dear Mr Hunt,

Thank you for your letter dated 26 November. I am writing to address the points you raise in sections two, three and four of that letter.

Section 2: NHS and care workforce wellbeing during the pandemic

At the beginning of the COVID-19 pandemic, it was clear that there was a need to strengthen the health and wellbeing (H&WB) support to staff to take account of the extra demands being placed on them. There is also evidence to suggest that healthcare staff are often hesitant to seek help and concerned about confidentiality when doing so.

As a key workstream within the Chief People Officer's Workforce Cell, the national H&WB programme therefore sought to augment support available to staff locally. Many organisations responded swiftly with enhanced local H&WB services and a stocktake revealed where the national programme could ensure a consistent offer for all our NHS people.

The national H&WB programme is designed to provide a spectrum of self-care and primary prevention through to mental health assessment and treatment. Drawing on the advice and experience of a swiftly convened Expert Advisory Group comprising experts with relevant experience in, for example, the Ebola crisis, Manchester bombings, and military responses, an evidence-based approach was taken within a trauma-based framework:

- **Prepare** – Helping people cope for themselves and building in line- management and team support to do so. This recognises that investing in prevention, briefing and preparation will lead to more positive outcomes.
- **Active** – When staff are in the 'eye of the storm' and the demands can seem overwhelming there is little 'head space' for them to attend to their own wellbeing as well as to provide the care needed for patients and their families.
- **Recover** – It is likely that for many staff psychological difficulties will present after the most intensive phase is over, as people reflect on events and replay them.

NHS England and NHS Improvement

It is important to differentiate between a normal and healthy reaction to abnormal events and excessive stress and more serious ongoing concerns which may require specialist support.

The NHS People Plan 2020/21 was published in July, with a strong emphasis on 'Looking after our People'—including 23 commitments related to health and wellbeing—and 'Belonging in the NHS' with a focus on addressing inequalities within the NHS workforce. The strengthening of the H&WB support to NHS staff described in this paper is aligned with the commitments set out in the People Plan. The People Plan itself supports delivery of the NHS Long Term Plan by ensuring that we have more people (both new and by

retaining our current people), working differently (more productively, using their full range of skills, enabled by technology) and in a more compassionate, inclusive culture.

Action taken so far and the impact and learning

During the early months of the outbreak, a comprehensive online platform was rapidly developed and made available to staff through www.people.nhs.uk. Key elements of the offer include:

- **Free use of several market-leading apps** to improve health and wellbeing to NHS staff (e.g., Headspace, Unmind, Sleepio)
- **Dedicated, confidential staff telephone helpline**, in partnership with The Samaritans, and a 24 hour text service
- **Structured debrief and support mechanisms**, such as leadership circles, and REACT (Recognise, Engage, Actively listen, Check risk, and Talk)
- **Support packages aimed at staff and line managers** including virtual Common Rooms and a range of online resources, guides and training
- **Free coaching, mentoring and support to staff**, including a specific offer to primary care
- **A support package for executive leadership** in conjunction with the Academy of Leadership and Lifelong Learning
- **The development of a tailored offer for Black, Asian, minority ethnic (BAME) staff**, recognising the disproportionate impact of COVID-19 on people from diverse backgrounds
- **A series of wellbeing webinars** for those working to support NHS and care staff health and wellbeing

Ongoing evaluation ensures continuous improvement and swift response to need. For example, the development of a culturally competent Tagalog bereavement service in partnership with Hospice UK for our Philippine colleagues.

We've seen staff use the self-help apps, text services, online forums and telephone helplines over half a million times to date, with a specific breakdown across the offer as follows (data as of 11 November 2020):

- 157,208 app downloads
- 379,616 website sessions by 334,276 users
- 9,172 contacts with our dedicated helplines
- 2,750 leadership circles
- 940 common rooms
- 1,252 coaching and mentoring sessions

- 1,244 REACT participants
- 3,706 primary care coaching sessions (1,239 further booked)
- 16,256 online views

The H&WB Expert Advisory Group has helped ensure that the content of the packages available to staff are evidence-based and responsive to emerging evidence of the impact of the COVID-19 response on the wellbeing of NHS staff.

The evaluation of health and wellbeing support has provided evidence that a significant number of staff are accessing it and that the programme is helping staff through access to self-help; supporting resilience and reflection; supporting leaders and managers; helping staff to support colleagues. Feedback from staff accessing offers has been highly positive, with satisfaction ratings routinely recorded over 90%.

We are closely reviewing emerging evidence assessing the psychological and wider impacts of the COVID-19 pandemic on NHS staff. Academic research, such as the NHS CHECK study, will be considered to identify how best to support our workforce during pandemics.

Strengthening the support available to staff this winter

During the winter we are enhancing this offer with two major programmes of work with a combined investment in 2020/21 of £30m which Claire Murdoch, our National Mental Health Director, announced at the hearing on 20th October;

- Staff Mental Health Support:

i. Mental Health and Wellbeing Hubs will provide proactive outreach and assessment services to all staff, giving staff rapid access to mental health support.

ii. A nationally commissioned complex case service is also being established to support staff who have been assessed by the hubs as having additional mental health treatment needs (e.g., complex addictions and co-occurring mental health problems).

iii. We are also procuring psychological and mental wellbeing training for critical care nursing staff to be delivered over the Winter.

- Enhanced occupational health and wellbeing support across 14 health systems prioritised by regional teams, which collectively cover 700,000 NHS staff. In many cases this support will also extend to other health and care staff, such as colleagues in social care. The programme will be evaluated both at system level and nationally to assure the impact and maximise the learning.

The mental Health and Wellbeing hubs and the enhanced occupational health offer build on what is already in place to create a tiered pyramid of support ranging from preventative care through to specialist support. Staff access the first tier of support themselves; local specialist help is available through occupational health and specialist support is accessed via the regional mental health hubs.

Further developments to the offer include:

- Extending the free access to health and wellbeing apps to NHS staff until the end

March 2021, funded nationally

- Development of an accessible physical health offer in partnership with Invictus Games Foundation
- Financial wellbeing support in partnership with the Money and Pensions Service (MAPS)
- Violence reduction training and extending the pilot of body-worn cameras in the ambulance sector
- Implementing H&WB conversations for all NHS staff, including new joiners as detailed in the People Plan 20/21
- Introducing 'Leadership lifeguards' to provide coaching and support to line managers
- Further development and research into the offer to BAME staff and networks, including working in partnership with faith groups
- Family and relationship support in partnership with specialist providers
- Continued partnership working across NHS England and Improvement People Directorate, Mental Health Team, and Regional Team colleagues

The evidence suggests that the impact of this period of extended demands on staff may last for some time for some staff, and therefore provision will need to be made for ongoing funding beyond 2020/21, to make it a sustainable part of the support we provide for our staff.

The measures I have outlined above are designed to mitigate the psychological impact of these pressures, however it is also critical that we continue to increase workforce supply and improve the retention of staff, and I provide further detail on how we are doing this in section four of this letter.

Section 3: Support for BAME NHS staff members

In response to your request for a comprehensive definition of the racism and discrimination that we are seeking to eradicate from the NHS, our approach is aligned to the respective definitions in the Race Relations Act 1976 and Equalities Act 2010. (I attach at Annex A the legal definitions of discrimination and racism which we align to from the Equalities Act 2010 and the Race Relations Act 1976 respectively.)

Our work to address racism and discrimination is multi-faceted and covers the following areas:

The Workforce Race Equality Standard (WRES)

The WRES was launched in 2015 provided data and evidence on the disparities in experience between black and minority ethnic staff and their white colleagues. The need to ensure BAME staff are treated fairly and their talents valued and developed is one that all NHS organisations need to meet.

The WRES remains the NHS's primary tool in highlighting disparity of opportunity and experience for ethnic minority staff in the NHS. The WRES draws data to assess the relative experiences of white and BAME staff against nine indicators relating to disparities of opportunity, experience, and representation in the workplace.

The WRES has been embedded within the NHS standard contract, CCG assurance framework and within the CQC 'well-led' domain inspections of hospitals.

We are currently finalising the WRES 2020 report, that will set the context for how we entered the pandemic. We also intend to publish a Medical WRES for the first time, as we look to delve deeper into the issues facing BAME staff in particular professions. The Medical WRES will include consideration of the pay gap, revalidation, complaints and differential attainment.

Action on race

To tackle some of the specific issues highlighted by the WRES since 2015, in July 2020 NHSE/I set out clear actions that employers should take to address ethnic disparities in their workforce including:

- An overhaul of recruitment and promotion practices to make sure that their workforce reflects the diversity of their community, regional and national labour markets.
- Publication of progress against the Model Employer goals to ensure that at every level, the workforce is representative of the overall BAME workforce
- Closure of the ethnicity gap in entry to formal disciplinary processes.
- Reviewing their governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.
- CQC will place increasing emphasis on whether organisations have made real and measurable progress on equality, diversity and inclusion

We Are The NHS: People Plan 2020/21 – Action for us all sets out our priorities and describes the issues we are committed to addressing. We have asked employers to take action against the following areas:

- Recruitment and promotion practices
- Health and wellbeing conversations
- Leadership diversity
- Tackling the disciplinary gap

- Governance
- Accountability
- Regulation and oversight
- Building confidence to speak up

Further detail on each of these actions can be found Annex B.

As an example of the work we are undertaking, I enclose the London Workforce Race Strategy (Annex C) which is helping to drive a step change in improving the experiences of our Black, Asian and minority ethnic (BAME) colleagues and make the NHS a more inclusive, fair and equitable place to work.

Key recommendations from the strategy are as follows:

Recommendation 4: Increase BME representation among Freedom to Speak Up Guardians and champions and ensure support is available across the system, including within primary care

Recommendation 7: Work with the Care Quality Commission to develop specific race related key lines of enquiry for inspections

Recommendation 13: Identify and close the gap in experience for agency, bank and temporary staff

NHS Race and Health Observatory

In addition to the above, the NHS Race and Health Observatory, launched this year, supports work in these areas with the following key functions:

(i) catalyse and facilitate high-quality and innovative research evidence;

(ii) make strategic policy recommendations for change; and

(iii) help facilitate practical implementation of those recommendations.

Work to improve the experience of BAME staff in the NHS

COVID-19 further served to underline the differences in the experience of BAME staff. We acted quickly to launch a comprehensive programme to address the impact of COVID-19 on our BAME workforce with five streams of work:

(1) Protection of staff,

(2) Rehab and recovery,

(3) Communications,

(4) Staff networks and

(5) Representation in decision making.

As part of this response, legal obligation for every NHS organisation was set out, specifying the need to manage the health and safety of their employees. NHSE/I sent a clear instruction to all NHS organisations on 29 April 2020 to risk assess staff at potentially greater risk. This was in advance of the Public Health England (PHE) report commissioned by Department of Health and Social Care (DHSC) to investigate the disproportionate impact on BAME communities.

On 24 June, NHSE/I issued a further letter to NHS organisations setting out the requirements for organisations to deploy staff risk assessments within two weeks, for completion—at least for all staff in 'at-risk' groups including BAME staff—within four weeks. This included a recommendation to make compliance data available to staff groups as an important part of reassurance and transparency. We conducted a final national data collection on 2 September.

Over 1 million conversations have since taken place with staff, including 96% of BAME staff, to improve their protection, health and wellbeing at work. We also completed a study into the fit testing and diversity of FFP3 masks, establishing a disparity in fit for BAME staff, producing a new algorithm for fit testing, and recommending changes to the procurement pipeline going forward.

We have also improved our engagement with staff with regular webinars and drop-in sessions with BAME staff network leads and the establishment of a BAME Clinical Advisory Group, chaired by the Chief People Officer. This group of some of the most senior and influential leaders in the NHS recently met for the first time and is designed to ensure the priorities of ethnic minority staff are heard and are influencing the national pandemic response. The first meeting focused on vaccinations, where we discussed mistrust and misinformation around vaccines and how best to engage BAME staff and communities.

Section 4: NHS workforce planning

We are at present working with our partners in DHSC and Health Education England (HEE) to determine the best possible allocation of the resources made available by the Government in the recently announced one-year Spending Review settlement for education, training and related purposes in 2021/22.

That will of course require HEE to examine, with its partners, its funding for the expansion of training places, supporting enhanced training and development for existing staff, delivering manifesto commitments, and supporting delivery of *Long Term Plan* goals. We expect these discussions to conclude in good time to influence the supply of training places for the academic year 2021/22. HEE, DHSC, and NHSEI will stand ready to support the Committee's scrutiny of those allocative decisions in due course.

Regarding a current overview of the NHS workforce, I would make the following points:

- The NHS workforce has grown by 9.2% between April 2018 and August 2020, an increase of over 97,000 full-time equivalents (FTE)
- Over 61,000 FTE of this growth has happened in the last year (5.6%), of which 29,000 are registered healthcare professionals (5.0%)

- From the beginning of the pandemic in March through to July, the NHS workforce grew by 30,000 FTE.
- Vacancy numbers and rates have been consistently falling since their peak in July 2019 and are now reported by trusts as being 23,000 lower than last summer.
- The focus on making the NHS the best employer, outlined in the People Plan, is beginning to have a positive effect on staff retention. Leaver rates from the NHS (excluding movement within the NHS) have fallen from a peak of 8.9% in December 2016 to 7.7% in March 2020.
- Universities in England placed 5,000 more nursing applicants than in 2019, an increase of 23%.
- The number of placed applicants in English medical schools is 8% higher than 2019 and 34% higher than 2016. And early indications are positive from the 2021 cycle, with the number of applicants increasing by a quarter.
- The highest ever number of people have entered GP training.
- Leaver rates have fallen further during the pandemic (to 6.7% by September 2020) but we expect this may be temporary as people extended their service during the pandemic. We are of course acting to retain as many people as possible on a permanent basis.
- We are working closely with the Department for Health and Social Care to deliver the Government's manifesto commitment for an additional 50,000 nurses by March 2024.

I hope this addresses the points in your letter dated 26 November 2020 and I look forward to the Committee hearing planned for early 2021 to discuss the impact of COVID-19 on our BAME colleagues.

Kind regards,

Prerana Issar

NHS Chief People Officer

Letter from Simon Stevens

14 December 2020

Dear Jeremy

Core NHS services during the Covid pandemic

Thank you for your letter of 26 November 2020 on core NHS services during the Covid pandemic. As requested, this note is to provide a further update on item 1 (waiting times and the backlog). NHS Chief People Officer Prerana Issar has already responded on items 2–4 of your letter, and DHSC may wish to reply further on the wider workforce questions you raise and which fall within their purview.

Impact of the pandemic on non-Covid health services: international comparisons

I know that the committee has been interested in comparisons with the international covid experience, so it is noteworthy that knock-on impacts to non-covid health services have also been widespread in other European countries. As the OECD's just-published 2020 edition of 'Health at a Glance: Europe' sets out:

> ''In response to the COVID-19 crisis, many countries postponed *elective surgery* to free up human resources and hospital beds. This was the case, for example, in Germany and Portugal for all non-urgent elective surgeries. ln France, the Academies de medecine et de chirurgie estimated around 1.1 million non-urgent surgical acts were postponed during the pandemic."
>
> "There have also been fewer visits to *emergency departments*. In France, fewer emergency visits were observed early in the crisis for people requiring urgent care for cardio- and neuro vascular pathologies. Moreover, a study in Paris found that the incidence of out-of-hospital cardiac arrest doubled during 16 March to 26 April, as compared to the equivalent time period in previous years. In Germany, the COVID-19 pandemic was associated with a significant decrease in all-cause admissions (30% lower than for the same period in 2019) and admissions due to cardiovascular events in the emergency department (41% lo wer). In Italy, paediatric emergency department visits were down by 73–88% in March 2020 as compared with March 2019 and 2018."
>
> "Beyond acute care, large reductions in the use of *outpatient services* have been reported in some countries, including Belgium, France, Gennany (Bavaria), Norway and the United Kingdom (England), though the number of teleconsultations has increased substantially. France also reported fewer specialist care appointments."
>
> "Disruptions to *cancer care* have also been evident. In the Nether lands, data from the Cancer Registry show a notable decrease in cancer diagnoses as compared to before the COVID-19 outbreak. In France, the number of cancer diagnoses decreased by 35–50% in April 2020, as compared to April 2019. In Italy, an estimated 1.4 million fewer screening exams were perfonned during the first five months of 2020 compared to the same period in 2019,

> leading to fewer cancer diagnoses. In Spain (Madrid), outpatient visits in oncology departments decreased by 23% between 9 March and 13 April 2020, as compared with the same period in 2019. New oncology referrals and the number of patients enrolled in clinical trials also fell, suggesting treatment delays.
>
> ''Many countries saw peaks in discharges from *mental health* care in March and April, linked to the recommissioning of inpatient beds or staff for COVID-19 wards, as well as lo the risk of COVID-19 transmission. In Madrid (Spain). in March 2020 the number of inpatient psychiatric beds was reduced by 60%, outpatient units were closed, and the number of patients altending emergency psychiatric services fell by 75%. Multiple reports from OECD countries also suggest significant reductions in the number of referrals to mental health services, mental health services contacts, and active community caseloads during the peak of t he spring COVID-19 outbreak. In the Netherlands, for example, the impact has already been significant: the number of referrals to mental health care fell by 25–80% after the outbreak; demand for treatment dropped by I 0–40%; billable hours decreased by 5–20%; and bed occupancy dropped by 9%."

The overarching inference to be drawn from this Europe-wide evidence is that the best way of ensuring comprehensive health services can continue to function well is to ensure effective public health measures keep SARS-COV-2 infections under control.

The second covid wave now under way

In practice, however, we have again had to respond to a rapid increase in eovid-positive hospital inpatients—from fewer than 500 at the start of September to nearly 15,000 in late November. Despite intense pressures in some parts of the country, the NHS in England has generally been able to adapt its response to this second covid wave, meaning less disruption to other non-covid services than during the first.

Additional revenue and capital funding made available to us has allowed some capacity strengthening. Our 'Help us Help You' public information campaign has encouraged people to continue to come forward for needed care. And improved community testing and infection surveillance has meant the NHS has been provided with more granular and timely infonnation on covid prevalence. This llas allowed individual hospitals, local areas and regions to deploy mutual aid, and flex covid and non covid service provision, in close to real time.

As a result, during the second covid wave this Autumn, for every <u>one</u> covid inpatient in hospital at any one time, hospitals have been able to look after <u>at least five</u> other inpatients for other health conditions. This compares with the Spring peak of first covid wave hospilalisations, when the ratio was one covid inpatient to two non-covid inpatients.

Outlook for winter and 2021

There are—to state the obvious—major unknowns about the wider demands that will be placed on the NHS over the coming months. These uncertainties are a function of the effectiveness of wider public measures to control covid infection rates, including through the Government's test and trace programme as well as the approach to geographical

tiering and related measures. We are currently not seeing the hoped for fall in covid inpatients following what was assumed to have been the second November peak. Instead, overall inpatient nwnbers have continued to increase, and are now higher than a fortnight ago. The Government have today identified the position in parts of the south east and in London as particularly concerning.

In the absence of knowledge about covid infection rates and therefore covid inpatient numbers over the coming months, forecasts of waiting lists and backlogs of care are therefore at this point unlikely to be accurate. For example, the Health and Social Care Committee's report of 1 October 2020 referenced at paragraph 24 a third party forecast that "the overall waiting list could grow from 4.2 million to 10 million, or possibly more, as a result of the pandemic" by Christmas. It is now clear that this is extremely unlikely to be the case. The most recent official statistics published last week (for October 2020) show 4.5 million people on the waiting list, still below the same time last year. The overall waiting list is currently increasing relatively slowly and last month the median wait for planned care again fell. And since July, the number of people waiting over 18 weeks has fallen by around 620,000 people, or nearly 30%.

Furthermore, while the number of Referral to Treatment 'clock starts' have rebounded from around one third of their usual level in April to over four fifths in October, there is uncertainty as to how that will net out over the coming months.

Despite this, we believe there are a number of important 'no regrets moves' which we are putting in place to reduce waits for elective and other care over the coming months . These include:

- **Maximising effective treatment capacity** both in NHS hospitals and through the independent sector, including—where locally feasible—dedicated non-covid treatment hubs. Prior to the second covid wave, we had seen strong elective recovery across the NHS, with overnight elective operations approaching 80% - 90% of their usual levels.

- **Increasing funding for elective care** going into 2021/21, making use of the additional £1bn allocated for this purpose in the November Spending Review. There is a cohort of patients waiting for non-urgent but important routine care who have, or will have, been waiting over 52 weeks. They - together with those needing urgent surgery - are a clear priority for hospitals (not least given the pre-covid success of the NHS in all but eliminating this type of wait).

- Investing in **expanded diagnostics**, including deploying an extra £325 million of capital investment next year to kick-start implementation of the new diagnostics model set out in the report I recently commissioned from Prbfessor Sir Mike Richards.1 Despite infection prevention and control impacts, we have seen strong recovery in diagnostic imaging volumes which are now in many cases running at over 100% of usual levels.

- Total **cancer treatment** volumes on the 62 day pathway are now reported to be back to and in a number of cases above usual volumes. A specific cancer care recovery plan (enclosed) has been developed by the national cancer team in conjunction with partners in the sector.

- A specific plan is also being drawn up with our partners in the **mental health** sector to allocate the extra £500 million made available in the November Spending Review to respond to additional needs which have arisen during the pandemic. This funding will be in addition to the real terms mental health funding growth already programmed in for next year in line with the NHS Long Term Plan.

We will be taking stock across the NHS on all these programmes early in the New Year in order to set appropriate operational goals for 2021/22. We will of course be happy to keep the Committee updated as we do so.

With best wishes,

Yours sincerely,

Simon Stevens

NHS Chief Executive