East London Health & Care Partnership

North East London's response to the Covid-19 pandemic – next steps (Phase 3)

October 2020

Summary

This plan summarises the East London Health and Care Partnership planned response to the Covid-19 pandemic from October 2020 onwards.

From 1 Aug 2020 the NHS Emergency Preparedness, Resilience and Response (EPRR) incident level moved from Level 4 (national) to Level 3 (regional) control

Acting in a way that takes account of lessons learned, and utilises beneficial changes; systems are required to accelerate the return to near-normal levels of non-Covid health services before winter, with a focus on:

- Addressing inequalities present both in the community and in our workforce
- Providing enhanced mental health support
- Restoring community and acute services
- Developing and protecting our workforce; growing it, retaining and sharing staff across organisations.

We will continue to work collaboratively through these challenging times, striving to constantly improve the care we provide.

We pay tribute to our amazing staff who have gone above and beyond the call of duty – truly adhering to the founding principles of the NHS, to deliver compassionate and professional care to those who have need it, regardless of status**,** wealth**,** ethnicity**,** age or gender**.**

1. Addressing inequalities in north east London

People from Black, Asian and Minority Ethnic (BAME) communities, people who have long-term conditions or obesity, and those living in more deprived areas are among those at greater risk of adverse outcomes from Covid-19 including death. The diverse communities of North East London (NEL) are more than 50% from BAME backgrounds, we have high levels of obesity and long-term conditions, and NEL contains some of the most deprived areas of the country.

North East London has endured some of the highest Covid-19 mortality rates in the UK. Whilst the longer-term consequences of the pandemic are not yet known, there is concern across that the pandemic is exacerbating existing inequalities and creating new ones. For example, in August 2020 there were 326,000 employments furloughed across NEL. This is likely to have significant impacts on health inequalities in future.

To respond to this, we are committed to increasing our efforts to reduce health inequalities. We will work to embed an approach to equity across everything we do as a Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS). We will also work closely with NHS England (London Region) and the new London Health Equity Group on action to reduce health inequalities at the regional level.

One element of work is the establishment of a health inequalities workstream, led by the London Borough of Newham Director of Public Health and a new public health consultant post. The work is focused on three priorities agreed with Directors of Public Health:

1. Inequalities data and analysis
2. Economic recovery and the 'anchor' system approach[1]
3. Supporting the pandemic response

1. Inequalities data and analysis

Data is collected and analysed by local Public Health departments, CCGs and others, yet this is often done in silos. Increased data access and sharing is paving the way for NEL-level analysis to inform and support decisions.

Intelligence and insight collated, conducted and interpreted by this group will inform the Covid-19 public health response, winter planning for primary care and work on the anchor systems approach.

2. Developing an anchor system approach

The economic implications of Covid-19 have the potential to be devastating for our residents and further exacerbate health and social inequalities. To mitigate this and any further impacts as a result of the EU exit, all health and care partners are meeting regularly to embed the *anchor system* approach and develop new opportunities building on some of the fantastic work already happening within local authorities and trusts.

One of the key areas of focus is developing an 'anchor charter' which ICS partners across NEL will sign up to as a way of harnessing collective action to address health inequalities. We are co-producing a set of principles to be included in the charter around employment and skills, procurement and social value, regeneration and estates, and climate action.

[1] An **anchor institution** is one that, alongside its main function, plays a significant role in a locality by making a strategic contribution to the local economy.

In September, we held the first in a series of events for stakeholders with an audience of more than 100 people. The events provided an opportunity to share local ideas, help define opportunities for collaboration and to gain input into the anchor charter for north east London.

3. Supporting the pandemic response

We aim to deliver an equitable and collaborative approach to the Covid-19 response across north east London.

In addition to our recovery programme and work in our three Integrated Care Partnerships[2] (ICPs), we welcome the renewed focus on health inequalities at a national and London level and are committed to supporting delivery against the following eight urgent actions:

1. Protect the most vulnerable from Covid-19
2. Restore NHS services inclusively
3. Develop digitally enabled care pathways in ways which increase inclusion
4. Accelerate preventive programmes
5. Support those who suffer mental ill health
6. Strengthen leadership and accountability
7. Ensure datasets are complete and timely
8. Collaborate locally in planning and delivering action to address health inequalities.

[2] One in each of three areas: 1. Barking and Dagenham, Havering and Redbridge 2. City and Hackney 3. Waltham Forest, Newham and Tower Hamlets

2. Mental Health

We have an ambitious vision to improve quality and outcomes for people with mental health problems, which we articulated in our Long-Term Plan.

During the first phase of Covid-19 our mental health services stepped up to provide safe and effective care for our most vulnerable patients. Through our rapid mobilisation of new crisis hubs, targeted support for people with the most complex needs, our digital offer for children and adults, our mental health services were essential to supporting system resilience during the pandemic.

Our work across systems (including local authority partners) protected people who were the most vulnerable, including those on the shielded patient lists, and people who are homeless, frail, or have mental health or drug and alcohol problems.

We have refreshed our plans to account for the significant demand suppression during the first quarter of the year, and the significant workforce pressures brought about by Covid-19; and we have developed new plans to support our delivery of the Long Term Plan, including for example our commitment to achieving zero out of area placements.

We are confident we are able to deliver on the Mental Health Investment Standard requirements, and to meet our Long-Term Plan commitments, but note the following risks:

- **Impact of suppression of demand**: many of our services experienced significant suppression of demand earlier this year. Whilst many services are now experiencing increased demand, there are some where demand remains below expectations, and where there may be risks to recovery by the end of the year (e.g. perinatal)
- **Impact of second wave of the pandemic** and further lockdown measures: there will likely be multiple impacts on operations, which will also impact on our ability to deliver our Long-Term Plan (e.g. impact of school closures on CAMHS access, physical health checks)
- **Workforce**: our plans rely on our ability to recruit into new roles, and assume limited numbers of staff off sick or self-isolating as a consequence of Covid-19. There are clear workforce risks associated with mobilising our new services in the current environment.

3. North East London Acute Alliance

The three acute Trusts in North East London: Barts Health NHS Trust (BH), Homerton University Hospital NHS Foundation Trust (HUH) and Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT), have come together to form an Acute Alliance.

The three trusts have set a shared ambition to deliver standardised, high quality, and equitable acute services. Working as equal partners the trusts have an ambition to reduce unwarranted variation, make the best use of the resources available within NEL to deliver high quality NHS care to those who need it and to reduce health inequalities.

The Acute Alliance will also have a focus on supporting the people who work in the NHS, addressing local workforce challenges and establishing north east London as a great place to work.

The Acute Alliance will support the local vision to deliver integrated health and care in line with the NHS Long Term Plan. However, the immediate priority is to accelerate the return of non-Covid health services and ensure that the system is well prepared for any future surge in Covid activity. The immediate priorities are therefore:

- Recovering maximum elective activity, including diagnostics
- Restoration of cancer services
- Planning for winter and any future peaks in Covid activity
- Acute workforce planning

With one of the most diverse populations in the country, we are aware of the need to ensure equitable access to services, with targeted communications and reasonable adjustments made for those who need them. Protecting patients and staff, including those who are most vulnerable from Covid-19, remains a priority and each of the trusts has a named executive board member responsible for tackling health inequalities.

The Acute Alliance is in its infancy, with the value that comes from working together as effective and equal partners expected to grow over time. Our plan takes account of the huge amount of work underway in each of the trusts and sets the ambition to go further and faster as new ways of working across the Alliance help reduce variation and make the best use of the resources available.

An early example of this will be the new specialist planned surgery hubs that will be established to help tackle the backlog of high volume, low complexity procedures, the true benefit of which cannot be quantified until the hubs are up and running. The Alliance will regularly track performance and aim to deliver additional activity that will enable it to reach national targets over the course of the year.

Our revised plans do not include the impact any future surge in Covid-19 activity may have on delivery. However, the Acute Alliance is planning how it will respond to any surge.

Recovering maximum elective activity, including diagnostics

Through the north east London Acute Alliance we are driving an ambitious, but realistic programme to restore and recover the elective and diagnostic position.

North east London will deliver around 12,800-15,200 elective procedures a month from October, equivalent to 90% of 2019/20 activity.

Surgical and day case activity

Overall elective and day case capacity has been significantly reduced in order to comply with infection, prevention and control (IPC) guidance. Delivery assumes compliance with current IPC rules and that appropriate testing is available to all those who need it.

A site review has identified 46 elective theatres, 223 overnight beds and 270 day-case beds as 'green' (NHS estate that can be kept 'covid-secure' even in the event of a second wave). Additional independent sector capacity has also been identified. To enable use of this green estate, all trusts are making adjustments to where services are provided.

Across the Acute Alliance, the normal work included a significant volume of additional weekend and evening sessions that were required to support waiting list management. Getting back to 90% elective and day case activity is being delivered through:

- Additional capacity as additional theatre become operational
- Increased productivity using the latest infection and prevention control guidance
- Expected reduction in patients not wishing to attend surgery or just not attending
- Widespread use of weekend and evening lists
- Targeted use of the independent sector

Trusts and the Alliance maintain a regular focus on performance and productivity, with further opportunities to maximise capacity and efficiency being explored through the hub model.

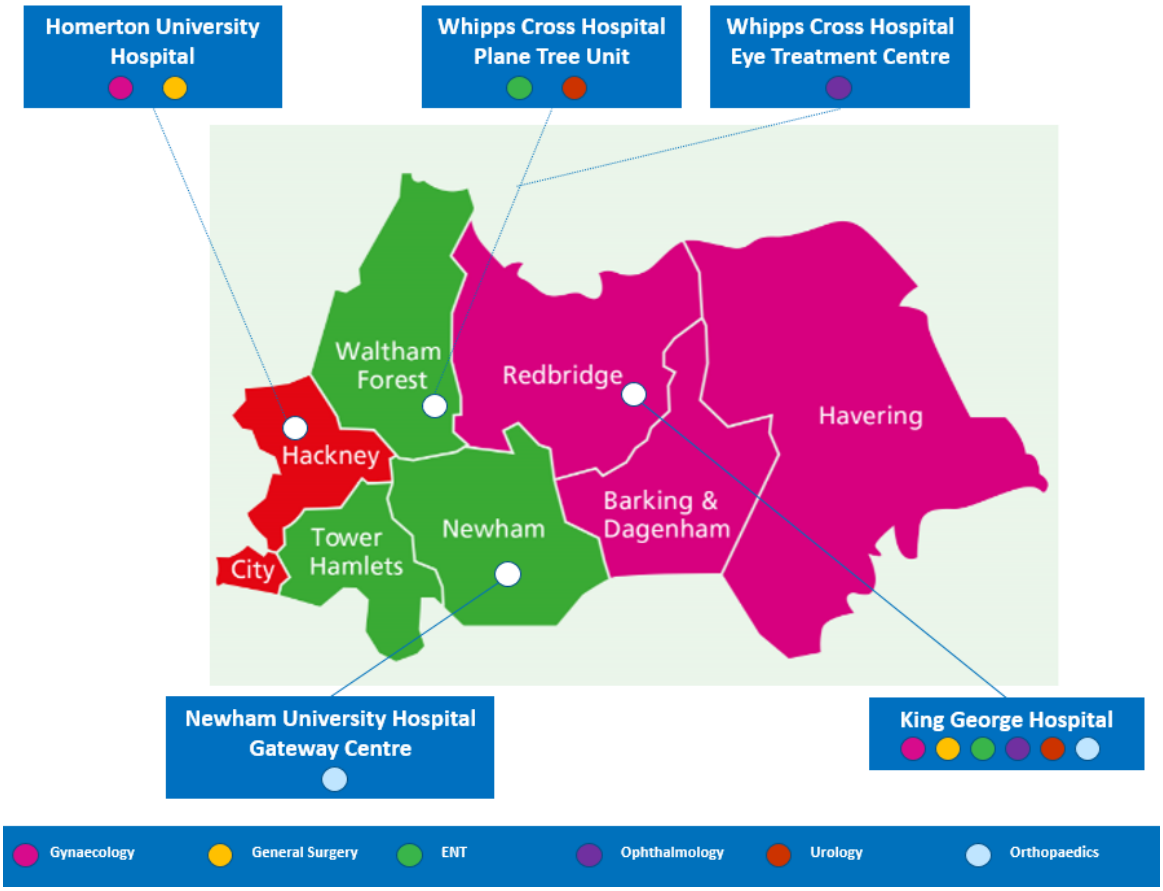
By identifying protected 'green' estate for elective work, services will be more resilient to any future surges in Covid-19 activity but it cannot prevent the impact of workforce challenges resulting from any future surge. The Alliance is modelling workforce options to minimise the impact of any future surge in demand for critical care, protecting as much elective and cancer care as possible.

Specialist surgical hubs

Alongside this work to restore overall elective activity, the Acute Alliance has developed plans to implement five high volume, low complexity elective specialty hubs in line with the London elective surgery recovery and transformation programme. These hubs will be centralised at four locations in north east London (see figure1). Each speciality will be delivered at two sites with a named lead provider.

Clinical oversight will be delivered through three workstreams of harmonisation, optimisation and standardisation with each of the three trusts in the Alliance being responsible for a work stream at speciality level. A quality improvement model, building on a similar successful model at the London Nightingale Hospital will be embedded within the hubs.

Figure 1: Location of specialist surgical hubs in North East London



The hubs will be established in three waves, allowing learning from the first wave of hubs to inform the development of those that are established later:

1. Wave one includes hubs for orthopaedics and ophthalmology. Sites for the orthopaedic hub are established at Newham University Hospital and King George's Hospital; along with sites for the ophthalmology hubs at Whipps Cross Hospital Eye Treatment Centre and King George's Hospital.

   We have transferred arthroplasty work from Homerton to Newham Hospital and dedicated cataract lists at the Eye Treatment Centre at Whipps Cross commenced in September.

2. Wave two includes urology and gynaecology, clinical summits are planned for October

3. Wave three includes general surgery and ear, nose and throat; clinical summits are planned for November to agree the development and design of the sites.

In addition to the six speciality surgical hubs identified by the London elective surgery recovery and transformation programme, we are looking to establish hubs for other high volume specialities. Examples of this include the new pain hub at Mile End hospital, and work to explore London-wide solutions to the paediatric dentistry backlog.

Whilst the surgical hubs are being developed and implemented, we will be taking the opportunity to consolidate some 'high volume, low complexity' lists at hubs to increase activity and reduce the backlog of patients waiting more than 40 weeks.

Outpatient activity

Outpatient transformation is being driven through the three local Integrated Care Partnerships. These programmes continue to drive improvements across outpatient pathways particularly through exploration of 'Patient Initiated Follow Ups[3]' for appropriate specialities – resuming activity, whilst being mindful of the need to reduce outpatient activity.

Each local outpatient transformation board is continuing to ensure trust capacity and resources are most effectively deployed at those that need it most, whilst supporting primary care to manage patients closer to home.

Infection control guidance (IPC) and the need for social distancing have required a radical re-think, shifting to more remote delivery and virtual appointments. Around 70-80% of appointments are now being provided virtually. Work is underway to understand why some patients are refusing to attend appointments. To comply with IPC guidance and social distancing, adjustments are being made to ensure patients are protected when coming in for face to face activity:

- Spreading clinics across acute and community estates in order to minimise the number of people attending one reception and waiting room
- Routine use of weekend and evening sessions to spread activity across the week

GP referrals are continuing to increase, in line with the "NHS is open and safe for patients" public communications messages, but still remain well below pre-Covid levels. Reduced volumes mean we are focusing on backlog management and how they can maximise future capacity. We continue to help patients feel comfortable using the NHS and to access care where they need it.

Independent sector

We have set up an Alliance independent sector (IS) hub that is overseeing all elements of independent work. This will ensure we maximise the use of availability capacity.

Our modelling assumes we have access to the equivalent of 8 theatres for 2 sessions per day over a 5 day week within the outer London hub until end March 2021, as well as access to capacity at the inner London hub for cancer and complex cases.

Our 2019/20 baseline included significant IS activity. However whilst contracts are currently in place to deliver this for outer London; additional inner London IS capacity is still to be confirmed.

Diagnostics

Significant activity is underway to increase diagnostic capacity across Computerised Tomograpy (CT), Magnetic Resonance Imaging (MRI) and endoscopy[4].

As set out in Figure 2, our plans will see the Alliance recover activity to over 90% of 2019/20 activity from October onwards. IPC requirements along with capacity and workforce limitations are preventing a return to 100% of BAU activity.

[3] Whereby patients choose the right time for them to book a follow up appointment (if at all), rather than be given a standard appointment at a standard length of time from their original procedure/care.
[4] Using a camera to look inside the body

Figure 2: NEL diagnostic activity projections

	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
MRI	81%	88%	95%	95%	95%	95%	103%
CT	89%	91%	91%	91%	92%	94%	108%
Endoscopy	78%	95%	95%	95%	95%	95%	105%

Imaging and diagnostics

A north east London Acute Alliance imaging and diagnostics hub has been established to oversee the restoration of all imaging across the sector. This will form the basis of the development of our imaging network.

The hub has agreed our local approach to imaging and is delivering a range of work, from standardising approaches to clinical prioritisation and clinical harm reviews to performance monitoring and implementing a way of utilising staffing across the three trusts to cover reporting opportunities, sharing expertise and cross cover.

The hub is working with the NHS London Imaging Recovery programme to consider options to increase activity compliance focussed around, for example, separate cannulation rooms to improve throughput; system on-call arrangements and increasing capacity with new equipment/mobile availability.

Endoscopy

An Endoscopy Recovery Programme Board now oversees delivery in north east London. Activity numbers have increased in September, resulting from workforce changes releasing staff redeployed/changes to medical rotas. Combined with changes in IPC guidance, the activity numbers are expected to increase per session.

Key actions include using alternative testing other than endoscopy; increasing endoscopy room capacity in ‘green’ zones; recruiting extra staff; bringing in extra equipment; developing diagnostic hubs and encouraging more patients to use their booked appointments.

Mile End Early Diagnostic Centre is set to open two rooms for endoscopy in Dec 2020.

Elective waiting times

Referrals to elective care are assumed to be at 90% by November, with a return to 2019/20 levels from March 2021.

A new Clinical Prioritisation Group has agreed a protocol to ensure patients are prioritised according to clinical need. We now have oversight of all patient waiting times in north east London. This will help us:

- Make best use of capacity and ensure equitable access
- Drive up productivity through standardisation
- Concentrate elective work on green or protected operating facilities that will not be impacted by emergency pressures
- Undertake specific ‘blitz lists’ which will focus on long waiters

The most patients waiting over 52 weeks are in orthopaedics, ENT, pain and paediatric dentistry – which will be targeted through the planned surgical hubs. This focus will also reduce reliance on the independent sector.

Restoration of cancer services

Cancer treatment performance has been achieved at Barts Health and Homerton Hospital in June and July 2020. BHRUT's performance has improved to 60% in July and the Trust has a detailed performance recovery plan in place, with planned erformance improving month on month. However we anticipate a decline in performance as we clear their diagnostic backlog.

The numbers of patients waiting over 63 and 104 day+ have continued to reduce. Key recovery actions are:

- Weekly cross-system Covid-19 recovery meetings
- Introducing 'C-the signs' software in primary care (5/7 boroughs) to improve cancer referrals made, with a plan to rollout to all 7 boroughs if deemed successful
- Ensuring sufficient screening, diagnostic and treatment capacity to meet rising demand
- Implementing new national infection control guidance to further release capacity
- Enhancing communications to reduce inequalities in access of services (in collaboration with partner organisations – Clinical Commissioning Groups, Primary Care Networks, Public Health England, cancer charities, local authorities, Healthwatch, community organisations etc..); promote services being open, and encourage patients to use primary care, screening, diagnostic and treatment services
- Ensuring sufficient staffing levels
- Further development of the rapid diagnostic centre models.
- Opening of Mile End Early Diagnostic Centre planned for December 2020, which will increase endoscopy and ultrasound capacity

A number of assumptions underpin the cancer trajectories, for instance that: patients will continue to seek primary care consultation for symptoms, resulting in urgent suspected referrals; that screening rates will come back to pre-covid levels and that capacity will remain the same as2019/20. However delivery will be tracked through the cancer alliance and the acute collaborative alliance.

Restoring urgent and emergency care services

This winter could bring unprecedented challenges, and the Acute Alliance has formed a winter planning, Covid-19 preparedness and critical care workstream. The new North East London Restoration of Urgent and Emergency Care services group is:

- Increasing NHS 111 capacity in line with the national Think 111 First campaign. There is an anticipated 20 per cent shift in patients contacting 111 who would usually walk into urgent treatment or emergency department services directly.
- Ensuring direct booking from 111 into all GP surgeries and community based rapid response services
- Developing pathways from 111 that avoid sending patients to emergency departments – some of these are directly into other hospital services, some are into primary care and community services
- Piloting an emergency department appointment service at the Royal London Hospital
- Piloting a virtual injuries service.

We have 185 funded and 14 additional open critical care beds, totalling 199, distributed across all our hospital sites.

We have a well-established critical care hub that has overseen the delivery of critical care across north east London throughout the pandemic and has developed surge plans to support a second peak. We have surge plans that will take us to 444 ICU beds. We will centralise the majority of our capacity at the Royal London Hospital. There are a number of significant dependencies required to reach 444 ICU Beds:

- Workforce: reaching our full surge capacity will have implications on planned care as we will need to draw on theatres and anaesthetic staff. We will work collaboratively as a group of trusts to minimise the impact on electives, and to ensure that we clinically prioritise the most urgent elective activities.
- Transfer and retrieval service: We will be reliant on the London-wide transfer service to safely move patients between hospitals across north east London

We do now have sufficient equipment to reach our surge capacity.

Across the system we are projecting to hit occupancy rates at just over 92.5% across all hospital capacity in months seven to twelve. However, within this, occupancy will be varied by trust, with Barts planning for 89%, Homerton for 90% and BHRUT for 96%.

BHRUT are 60 beds short of hitting their target occupancy. This includes the impact of opening an additional 43 beds at the King George's site and further risks include:

- This is based on high level modelling so does not take account of peaks and troughs in demand within each month; nor assumptions around a second Covid peak.
- This assumes full flexibility of the capacity that is not always operationally possible due to the need to safely segregate different pathways and cohorts of patients – eg. Covid and non-Covid, elective and non-elective and adults and children.

Further work is underway to further understand and secure our bed capacity position through winter and a likely second peak in Covid as follows:

- There may be potential to open further 22 bed escalation ward at Homerton, though this will be dependent on staffing and ensuring that this can be done whilst still allowing us to deliver Covid secure elective capacity.
- We are exploring the potential of a range of community-based schemes in development but which are not currently captured in the demand assumptions. These include community-based frailty services, discharge, community end-of-life care services and enhanced health in care homes. Delivery of all schemes may reduce the bed requirement by 166 beds. We are risk rating the expected impact and phasing of the impact.
- We are refining our modelling to better take account of how capacity will need to be segregated to deliver safe services.

Protecting elective capacity

We are planning to protect elective (green) capacity as far as possible through winter and through a possible second peak.

We have concentrated elective work on green sites as far as possible – however, the workforce may be challenged as if we need to increase ITU capacity we may need to move anaesthetists and theatre nurses.

We are modelling the impact opening additional critical care beds would have on elective and cancer care.

Acute Alliance Workforce

The challenges in NHS acute trusts will require a strong, supported and engaged workforce. We have established a workforce group within the Acute Alliance to focus on the workforce support and changes that are needed to deliver phase 3 recovery.

A range of measures (including a modelling tool) are being put in place to support our planning for different scenarios that may arise that would affect our workforce demand and supply. Ophthalmology and Orthopaedics hubs are being used to test the modelling tool.

We are ensuring a robust process for listening to clinical and operational staff to help shape workforce plans. This will be extended to mental health and community providers wherever the work is beneficial to these types of provider trust.

Dedicated support has been identified to establish a north east London bank of staff and develop a consistent approach to agency staff – which will address priority 3 of the London workforce priorities.

A north east London Social Partnership Forum has been established to aid discussions and negotiations around our ambition to create a more mobile workforce across our acute providers. The work needs to be scoped fully, with a clear plan to engage the various members of our workforce at all levels.

Reducing health inequalities in our acute workstreams

In conjunction with the wider focus on inequalities the Acute Alliance is committed to supporting a reduction in health inequalities and will work with all health partners to support a whole system population health approach. There are a number of specific actions the Acute Alliance will take to restore services inclusively and address inequalities:

- We will use our collective communications resources to support system-wide and regional communications to residents that the NHS is open and safe
- We will focus on improving the coding of patient and staff ethnicity; introduce routine monitoring of service usage by ethnicity and postcode - including for cancer screening services; and monitor patient refusals of elective care by ethnic group, so that we can undertake proactive engagement with specific groups and communities
- Where services are moved or centralised we will consider how patients can easily access them. This may include provision of transport for elective pathways
- Where we develop digitally enabled pathways, we will ensure that they increase inclusion, and ensure that there are multiple channels of engagement
- In the event of a second peak, we will protect elective capacity for urgent and cancer care as far as possible
- We will learn lessons from the first Covid peak, ensuring that we specifically consider how we can better support those communities and groups that were most impacted
- We will do all that we can to protect our staff from risk of Covid – through Personal Protective Equipment, Infection and Prevention Control guidance and provision of Covid secure workplaces
- We will develop a process for ongoing risk assessment of all staff, and specifically those from Black and Asian Minority Ethnic backgrounds

4. Risks

Risk and impact	Actions to reduce the risk
Lack of testing reagents reduce the number of planned elective procedures	• Working with London and National teams to increase local testing capacity
A surge of emergency and / or Covid activity reduces our ability to deliver planned elective and cancer activity	• Oversight through the Acute Steering Group and a dedicated workstream focused on winter, Covid and critical care planning • Alliance-wide workforce planning is developing options to respond to future critical care demand and maintain as much elective / cancer activity as possible • 'Green' estate identified for elective capacity to create greater resilience in any future surge • Engagement in London-wide planning
Lack of sufficient funding and capital investment mean plans will be undeliverable	• Capital bids submitted to Regional teams • Development of financial plans ongoing
Resurgence of Covid leads to changes in Infection Prevention and Control (IPC) requirement that reduce capacity for planned care	• Regular monitoring of IPC guidance and compliance • Modelling and reforecasting to be undertaken as guidance changes
People are reluctant to access primary and secondary care services leading to non-attendance, reduced activity against plan and increased ill-health and undiagnosed cancers	• Enhanced local communications to reduce inequalities in access of services targeted to patients, carers, primary and secondary care in collaboration with partner organisations (CCG's PCN's, PHE, Cancer Charities, Local authorities, Health watch, community organisations etc). The messages focus on services being open, encouraging patients to use primary care, screening, diagnostic and treatment services. E.g. a series of videos to give confidence in primary care and secondary care settings. • Plans in place for a north east London campaign to support the update of the Think 111 First service. • Focused communications being developed to specific demographics and communities to encourage access to cancer screening. • Local alignment with national and regional comms.
Limited testing capacity and slow turnarounds leads to more staff isolating, or staying at home for childcare, reducing ability to delivery activity as planned	• Alliance workforce workstream developing options to support system-wide workforce solutions, support for staff and redeployment where needed • Work with London and national teams to increase local testing capacity

5. Workforce

The implementation of our phase three response requires a resilient, flexible and healthy and supported workforce. We need to ensure we continue to grow, retain, and share our workforce across organisations.

Many programmes of work are already in progress. For instance we are redesigning teams using models that are clinically led, co-produced, supported by evidence and good practice with a focus on creating career pathways. We have a process in place to ensure risk assessments are completed for individuals identified to be redeployed and have options for shielded staff.

We have developed psychological support packages and a full range of health and wellbeing service for staff; flexible approaches for staff to take annual leave and investment in health and wellbeing hubs on multiple sites.

We have also identified the following initial areas for us to work together. These themes also address the national priorities set out in 'We are the NHS: People Plan 2020/21 - action for us all'

Health and wellbeing

- To listen to our workforce needs and develop our health and wellbeing offer
- To develop services that enhance psychological support for all health and care staff
- Work with academia and national bodies in learning from, and contributing to, research on what works
- A commitment to review and expand where appropriate flexible working options for staff and promote these through the recruitment process.

Culture

Recognising the rich diversity in east London, we will promote equality in our recruitment practices. We will align our strategies to create a compassionate and inclusive culture to improve staff experience in the workplace and serve our communities' needs

- Work together to transform recruitment and talent practices to strengthen inclusion and ensure our leadership further reflects the diversity in our population.
- Continue to show positive progress in workforce race equality standards (WRES) and workforce disability equality standards (WDES) outcomes
- Work together to operationalise the London Race Equality Strategy
- Develop a talent framework with programmes across organisations, ensuring our talent is developed and retained in our health and care organisations.
- Develop links with the new NHS Observatory for Race & Health, academia and national bodies in learning from, and contributing to, research on what works.

Supply and demand

- Build workforce capacity modelling to inform mobilisation and development of staff to meet required activity.

- Agreement to share our workforce across providers initially with a focus on acute transformation. To develop systems and processes across systems to support this including Memorandum of Understandings, induction, and training.
- Scope work on an Integrated Care System (ICS) bank of staff to improve staff experience, control costs and achieve mobility of staff across organisations

Primary and secondary care

- Continued development of rotational and portfolio roles to grow our General Practitioner and General Practice Nurse workforce.
- Ensure plans are in place to increase our workforce using the Additional Roles Reimbursement Scheme.
- Continued expansion of Physician Associate and Nursing Associate roles
- Work collaboratively on specific recruitment campaigns including overseas opportunities

Anchor institutions

- In September 2020 all partner agencies agreed on priorities for our north east London Anchor Programme. We will work across health and care as a minimum around a new apprenticeship offer for younger people as well as to focus on areas with staff shortages (e.g. social work, phlebotomy) to ensure we target training opportunities at local communities disproportionately affected by the economic downturn.
- Creating opportunities for our population, building on existing work of the Barking Havering and Redbridge academy, Health Horizons programme at Barts Health, North East London apprenticeship and return to practice programme.