NHS Health Education England

HEE GUIDANCE

Supporting the NHS during resurge phases of COVID-19 and the ongoing pandemic: managing the training workforce

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1. INTRODUCTION

HEE's role during a COVID-19 resurge: Managing the Training Workforce

Summary

1. This guidance outlines the process for governing HEE's decisions, operational activity and management of students and trainees during a resurgence of COVID-19 and expected winter pressures over the first quarter of the academic year. The guidance draws on HEE's experience and lessons learned from the first wave of the pandemic in March to July 2020.

2. The guidance describes the role of HEE's national and regional teams in supporting the training workforce during a resurge of the pandemic and if it intensifies into national or regional lockdown, specifically the management of decisions on deployment; examination, rotations, assessment and progression. Alongside this it provides an overview of national legislation, regulation and policy decisions which may affect the training workforce during a surge phase.

3. The training workforce for which HEE administers Department of Health and Social Care (DHSC) clinical placement tariff funding comprises healthcare students in undergraduate and pre-registration programmes in:

    - Nursing and midwifery
    - Allied Health Professions
    - Medicine
    - Dentistry

    and trainees undertaking regulated postgraduate training for which HEE administers:

    a) educational tariff:

    - Medicine
    - Dentistry

    b) salary contributions:

    - Clinical Psychology
    - Child Psychotherapy
    - Community and Specialist Nursing
    - District Nursing
    - Healthcare Science
    - Health Visiting
    - Hospital Pre-registration Pharmacy

4. Students undertaking undergraduate pharmacy and training programmes in other disciplines outside of the DHSC tariff regime that lead to registration or a qualification are listed in Annex A.

2. PRINCIPLES FOR MANAGING A RECURRENCE OF THE PANDEMIC

Key principles

1. HEE will support patients, health services and learners to face the COVID-19 resurge with the same effort, commitment, cooperation, problem solving and flexibility as during the initial emergence of the pandemic.

2. HEE is committed to supporting healthcare students' and medical trainees' wellbeing as they adjust to the challenges of the coronavirus pandemic and the necessarily different learning experience this academic year.

3. HEE will work with its partners to ensure trainees and students continue education and training and prioritise the restoration of all pre-registration and postgraduate education and training that has been impacted by the COVID-19 pandemic.

4. This time there are more effective treatments, a more knowledgeable population, new Test and Trace capability being built, a ready-made surge infrastructure, and greater understanding of the spread and what worked last time.

5. We also have winter pressures including influenza (flu); increasing pressure in waiting times; the necessity to maintain cancer services and urgent and emergency care; more nuanced population restrictions, which are potentially more difficult to follow; learners with fewer skills and less knowledge at this point in the academic year; tired and stressed staff on the frontline; and an increasing need to focus on other areas of care as well.

6. We will apply learning from the first surge to the different environment this time, in order to support the local and regional management of the COVID-19 response and support learners' educational and supervisory needs. This includes framing risk with a greater shared understanding of the range of factors, including ethnicity, which can mean a learner and some communities are more vulnerable to the virus.

7. Local and regional demand scenarios will allow the system to respond with appropriate interventions at transparent trigger points as the pandemic develops at different speeds in different places.

8. We need to recognise that building back-up to frontline staff will be harder this time. Returners who were not used last time may be less willing to come forward. Restoring a wider range of services for other conditions will also require more staff.

9. The availability of undergraduate / pre-registration students and post-graduate professionals in training is different to last time.

10. Undergraduates and pre-registration students do not have the knowledge, experience and skills of those who volunteered last time. Our first years are a month into their course. Our second years have no clinical experience because of volunteering in phase one. And our final years are so behind in their studies there is a real possibility of no graduates next year to join the NHS if there is further interruption.

11. Our postgraduate trainees, including junior doctors, have already lost a period of their specialty training. Further disruption will break the pipeline for middle grade doctors and Consultants for the NHS.

12. Therefore, HEE will need to plan a more focused response based on demand scenarios and triggers to protect learners and the vital graduate pipeline.

13. HEE's approach will be in three core areas:

    a. **New Supply** – it may be a challenge to attract returners during a COVID-19 resurge, as many will have been deployed or returned to their substantive roles; however, we will play our part by helping others who are leading on this to motivate and recruit former staff and identify areas where international recruitment may help.

    b. **Support for People in the NHS** – we will build on our widely regarded online education and training offer and support our clinical colleagues to provide training for staff at the point of care, as appropriate. We will also focus on the health and wellbeing of people in the NHS, learners and our own HEE colleagues.

    c. **Students and trainees (pre-registration, undergraduate and postgraduate)** – we will support learners to continue their education as much as possible in this fast-changing environment to protect the NHS' graduate pipeline. If necessary, we will work with stakeholders to redeploy trainees for COVID-19 response or urgent elective work within the principles of protecting trainees, the graduate pipeline, primary care and mental health.

14. Working in partnership with NHSE/I lead for Infection Prevention and Control we have identified several key triggers to be used in regions:

    a. Increasing Admissions to Acute Services >50 per 100K population cases
    b. Outbreak numbers 50 per 100K
    c. R Rate =/>1.0 (immediate review)
    d. Workforce Sickness and absence increases >3% of staff (need to check national average)
    e. Children's absentee rates (across all education years)
    f. Increase admission to Critical Care and V/O beds

3. SUPPORTING THE HEALTH AND WELLBEING OF LEARNERS AND TRAINEES

1. HEE continues to work closely with national, regional and local partners to ensure that the health and wellbeing of students and trainees is prioritised throughout their learning and training.

2. In the event of a COVID-19 resurge, learning environments should protect the physical and mental health of all students and trainees, keep them safe with the right equipment, support their wellbeing, and enable them to keep learning and training while they are fit and well, ensuring a safe and high quality educational and training experience.

3. The safety and wellbeing of our students, trainees and training staff is our priority as they begin a safe start to the new academic year. We know that many students are being offered a blend of online and in-person learning in COVID-19-safe settings, with Higher Education Institutions (HEIs) and NHS placement providers implementing national guidance on COVID-19 and risk-assessed placements and training environments.

Government COVID-19 Guidance

4. The Government has published national guidance for education providers and healthcare professionals on what they need to do during a coronavirus outbreak. The guidance documents are regularly updated and can be accessed here:

    - **COVID-19 guidance for further and higher education:** https://www.gov.uk/government/collections/further-and-higher-education-coronavirus-COVID-19-19

    - **COVID-19 guidance for healthcare professionals:** https://www.gov.uk/government/collections/coronavirus-COVID-19-19-list-of-guidance#guidance-for-health-professionals

NHSE&I Resources

5. As part of the NHS People Promise, NHS England & NHS Improvement (NHSE&I) has published a range of resources and guidance to support the health and wellbeing of NHS staff. These resources can be accessed here: https://www.england.nhs.uk/ournhspeople/online-version/lfaop/support-during-COVID-19/

Student wellbeing

6. The DHSC has updated its guidance to make it explicit that students on placement should be regarded as essential workers and be given the same priority access to COVID-19 tests as other healthcare workers. This guidance may help if a student needs a test and there are issues gaining access to one.

7. The Office for Students (OfS) is working closely with the Department for Education, universities and colleges to support and protect the interests of students, whilst recognising the immense pressure universities and colleges are under. The OfS has published guidance for providers and students which can be accessed here: https://www.officeforstudents.org.uk/advice-and-guidance/coronavirus/

8. Universities UK has also published a new checklist to guide universities that are supporting students who are self-isolating. This builds on previous guidance published to reaffirm and clarify the actions universities should consider to best support students' physical, mental and emotional wellbeing.

Learners who are shielding

9. There are a range of factors, including ethnicity, which can mean a person is more vulnerable to the virus. The factors might include age, sex, pregnancy after 28 weeks, or having an underlying health condition, such as: cardiovascular disease, diabetes mellitus, hypertension, chronic kidney disease, sickle cell or chronic obstructive pulmonary disorder. If a learner thinks that they might be at increased risk, they should be encouraged to contact and speak with their GP to discuss any health concerns.

10. The Government has advised those who are clinically extremely vulnerable (CEV) to shield, which means staying at home as much as possible and keeping outside visits to a minimum. Shielding in the UK came to an end on 1st August 2020 and the government is advising that students do not need to shield at the moment.

11. For those who are CEV and live in an area where additional public health measures require them to resume shielding, the government will write to advise them to stay at home and shield (Local Lockdown). In the event that a student or trainee is asked to shield again, guidance for learners who are shielding is available at https://www.hee.nhs.uk/covid-19.

Specialty/GP specialty trainees in at risk health groups, needing to shield, sheltered due to bereavement or anxiety or who are pregnant

12. These trainees should ideally have been identified in advance. They will already be known to both the Specialty School, training programme and the employer (which may be a lead employer organisation) and should be flagged on HEE's Trainee Information System (TIS). As it is likely that they will need to be placed in a lower clinical risk or remote working environment, they will not be included in these placement changes or short -term re-deployments. We aim to find alternative suitable placements for them as well as not including them in any email communication about re-deployments.

Addressing the impact of COVID-19 on Black and Asian learners who may be at an increased risk

13. The NHS has made it a priority to address the impact of COVID-19 on Black, Asian and some other ethnic groups who are at increased risk.[1]

14. We know that COVID-19 does not affect all population groups in the same way. Public Health England (PHE) has published data that shows people from some ethnic groups may be at increased risk of getting the infection, as well as experiencing more severe symptoms and in some cases have had higher rates of death.

15. PHE has also undertaken a review of disparities in the risk and outcomes of COVID-19; this shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19. PHE has reported that emerging evidence suggests excess mortality due to COVID-19 is higher in some groups from Black Asian and ethnic minority (BAME) backgrounds.[2] Individuals of Black African or Black Caribbean ethnicity may be of highest increased risk, with people of Bangladeshi origin and from other Asian backgrounds also being at risk.[3]

16. NHSE&I have highlighted the benefit of risk assessments that specifically consider the physical and mental health of Black, Asian and people from ethnic minority backgrounds, ensuring that everyone feels able and empowered to raise concerns safely. Details of a risk reduction framework are provided online.

17. NHS Employers has developed and published guidance, which is aimed at protecting staff who are from at risk groups. This guidance can be adapted to support learners from BAME backgrounds. This includes advice on how to adapt and enhance existing risk assessments particularly for at-risk and vulnerable groups, and Black, Asian and other people from ethnic groups with an increased risk. This information can be accessed at: https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/supporting-staff-health-and-safety.

[1] https://www.england.nhs.uk/coronavirus/workforce/addressing-impact-of-covid-19-on-bame-staff-in-the-nhs/
[2] Public Health England May 2020: Beyond the data: Understanding the impact of COVID-19 on BAME groups
[3] Office for National Statistics (ONS). Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020 [Online]. 7 May 2020 [Cited: 23 May 2020]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020

18. NHSE&I are creating a bespoke health and wellbeing offer (including rehabilitation and recovery) for BAME colleagues, this is being created in addition to the range of resources already available. This includes free to access dedicated bereavement and trauma support line for colleagues of Filipino origin based on feedback on our engagement. The free to access and confidential line, operated by Hospice UK 0300 303 11 15 is available seven days a week 8.00 am – 8.00 pm.

19. Bespoke COVID-19 counselling and bereavement support for people from Black and Asian communities is also being developed and delivered through civil society partners including:

    The Ubele Initiative through the Majonzi Fund: https://www.ubele.org/covid19-supporting-bame-communities; https://www.ubele.org/news/2020/4/22/launch-of-the-majonzi-covid-19-bereavement-fund

Life assurance

20. While students were on paid placements, they had access to the NHS pensions scheme, which included 'death in service' benefits in the event of death. In practice, the scheme was criticised as the benefits available through the scheme to the family of newly contracted students was seen as being very limited.

21. A temporary life assurance scheme was created this year in England and in Wales for the families of health and social care workers who die as a direct result of COVID-19 infection caught in the workplace.

    - In Wales, students are included in the list of eligible individuals.
    - In England, students on paid placement were eligible for this scheme but students on normal placements are not automatically eligible. The Secretary of State has discretion to make life assurance payments to the families of unpaid students if the individual case fulfils the scheme's following three criteria:
        - coronavirus disease was wholly or mainly the cause of death;
        - the individual was exposed to a high risk of contracting coronavirus disease in circumstances where they could not reasonably avoid that risk because of the nature and location of the work their work;
        - the individual contracted coronavirus in the course of their work.

22. The Department of Health and Social Care has produced a factsheet about the scheme in England which can be accessed here.

4. GOVERNANCE AND OPERATIONAL RESPONSIBILITIES

National, regional and local response level management

1. The likelihood of geographically targeted lockdowns in response to local and regional trigger points will require a regionally led approach to placement management, rotations and redeployment. This must be underpinned by a robust reporting mechanism to HEE's National COVID Oversight Group (COG).
2. The key principles of governance and reporting are to enable regional collaboration and decision making; to provide real time information to the COG and to ministers; and to facilitate regional and national trend analyses and mitigation planning to minimise disruption to the education supply pipeline.

Response level

3. Working in partnership with the NHSE&I Infection Prevention and Control, HEE has identified several key triggers to be used in regions, to determine whether a lock-down is required and at which level:
    - Increasing Admissions to Acute Services: >50 per 100K population cases
    - Outbreak numbers: 50 per 100K
    - R Rate =/>1.0 (immediate review)
    - Workforce Sickness and absence increases: >3% of staff
    - Children's absentee rates (across all education years)
    - Increase admission to Critical Care and V/O beds
4. There are three levels of lockdown responses that could be implemented across England, subject to the size and severity of the surge.

    a. **National response:** A national response or lockdown is the whole of England. This was experienced in March 2020 and HEE has a plethora of learning from this situation on the impact of recruitment, rotations and examination, assessment and progression of trainees. Where possible, learning suggests that a more effective response to a resurgence of COVID-19 is through the regional/local management of the training workforce.

    b. **Regional response:** This is a geographical response over the seven regions namely defined as North West, North East and Yorkshire, Midlands, East of England, South West, South East and London.

    The Regional Director (RD) for six of the seven regions is the senior individual to act as the SRO for the COVID-19 response. The RD and Postgraduate Medical Dean in the North East and Yorkshire are joint SROs for the regional COVID-19 response. The RD should ensure regular local communication and a "Silver Command" meeting is convened as appropriate which can be stepped up or down in frequency. The RD's will link with HEE national Gold command to ensure effective national and regional working.

    Enabling functions must also help deliver critical business as agreed at region wide level, meetings will remain virtual where possible and risk assessed against HEE COVID-19 operating model when there is a "real need" to meet face to face

    The Postgraduate Deans, regional nursing/AHP/Pharmacy/workforce transformation leads should be involved in the regional workforce cell to plan and manage the workforce response.

    The role of Postgraduate Medical Deans and Postgraduate Dental Deans will be critical in managing the interface between undergraduate and foundation training; and the quality management of the learning environment alongside assessment, rotation and progression of specialty trainees to mitigate against disruption of training, clinical teaching and clinical placements.

    HEE staff wellbeing must be considered in all modes of working to deliver HEE business, however there must be an assessment of business risk and personal risk.

c. **Local response:** This is a local footprint of the ICS and Trusts. In an example of a local response it is important to note that consideration must also be taken to the wider regional impact due to the infrastructure and distribution of training programmes.

- Agreement of local thresholds where all parties will act to put in place resurge response
- Redeployment should be based at local office/ICS level with the appropriate links in from HEIs, Arm's Length Body (ALB) regional and national workstreams and the appropriate links out to all areas including primary secondary and social care settings.
- There should be a local process for cascade of local and national communications. Ensure this network remains active.
- The following categories of staffing during a localised lockdown should be applied:

    a. staff who service the localised COVID-19 caseload, including NHS Nightingale staff
    b. staff who provide other critical functions such as cancer and other non-elective pathways
    c. Staff enabling flow (discharges and avoiding admissions e.g. community staff, GP, 111)
    d. Other staff (e.g. elective admissions) who can be redeployed

5. Decisions on redeployment must be based at local office/ICS level with the appropriate level of partnership working with HEIs, ALB regional and national workstreams and the appropriate links out to all areas including primary secondary and social care settings.

6. HEE is committed not to redeploy any students from their scheduled clinical placements, with the exception of extenuating circumstances in the event of a COVID-19 resurge. This is to avoid any further disruption to education, which could risk students being unable to complete the clinical and tuition hours required to achieve professional registration. Any redeployment of postgraduate trainees requires the approval of the postgraduate dean, as the Responsible Officer.

Regional action to develop the right response

7. Understanding the response level: Agreement of local thresholds where all parties will act to put in place resurge response. Ensure as much routine educational activity is delivered until a surge as defined and significantly challenging capacity is confirmed.

8. Gathering data and intelligence: Ensure data access with regards to any local modelling, and provide timely reporting to HEE COG to enable preparation for potential COVID-19 scenarios. This could be regional or local and might include:
    - Numbers and details of redeployed workforce
    - Numbers and details of paused rotations
    - Trainee progression data
    - Numbers of shielding learners
    - Student COVID-19 infection numbers
    - Prediction of admissions and capacity
    - Test and trace data
    - Outbreak data
    - Bed occupancy
    - Staff sickness
9. All regional teams should be familiar with the NHSE/I EPRR plan: https://www.england.nhs.uk/ourwork/eprr/ and how this will be enacted locally.

Governance and reporting

10. HEE established the National COVID-19 Oversight Group (COG) on 20th March 2020, to oversee the work of existing groups related to the work and planning of COVID-19 and provide a point of coordination with all decisions and communications to be issued by COG. This ensures alignment with the wider system and Government activity in which HEE is involved.

11. The COG meets every week on a Thursday and overall accountability for the direction of COVID-19 within HEE sits with the HEE Chief Executive Officer (CEO) who is designated as the Gold Commander and Accountable Officer (AO). The frequency of this meeting will be reviewed, with the option to schedule more regular or ad hoc meetings as the need arises.

12. Postgraduate Medical Education (PGME) data on the COVID-19 impact on trainee rotations and deployment will be reported weekly, alongside ARCP outcome data and numbers of shielding trainees to the Senior Leadership Team in the HEE National Directorate of Education and Quality. This will then be reviewed by HEE COG.

13. Escalation flow diagrams for non-medical & dental placement management and for medical & dental placement management are set out in Figures 1 & 2, respectively. The process flows set out the steps that regional teams should take to monitor scheduled activity prior to and during a potential lockdown, in order to assess potential impacts and take mitigating action.

14. Regions will report to the COG at the point that a lockdown impacting the region is announced, providing an initial assessment of placements affected, including numbers and rotation dates. This data will be discussed with the regional director and national team, who will develop proposals, including review and debrief dates.

15. Regional teams will liaise with HEIs, placement providers and the regional NSE&I team to agree plans for placements and deployment.

16. This data will be incorporated into proposals – including rotations, re-allocation and impact on training – and signed off by the Regional Director and National team for further reporting to the COG. The template that regions will be using to report to the COG can be accessed here:

20201016 Regional
Office reporting temp

17. HEE will report weekly to the Medical Schools Council on the impact of local lockdowns and any wider COVID-19 disruption on undergraduate clinical placements. This report will be supported by advice and assurance of the mitigation and management of the impact on student progression. This reporting will be co-ordinated by the Education Funding function.

Communication across the system

18. HEE will have a clear procedure for communicating changes to national policy and processes affecting the training workforce to regional and local offices. During a resurge, this communication should be daily to support regional and local offices support the local training workforce and stakeholders.

19. HEE's COVID-19 webpages will be regularly reviewed and updated where required to ensure the publication of timely, accurate and relevant information for learners, educators and placements providers.

20. Statements, resources and guidance will be reviewed and signed off by HEE COG and Communications Group, prior to publication on HEE's website. Regional Directors, Postgraduate Deans and Regional Clinical Leads will receive timely notification of new web content as it is published.

21. There should be a local/regional process for cascade of local and national communications. It is important that the regional governance drives operations, however central governance is required for reporting. This should be supported by national communications.

Three tiered COVID-19 alert level and impact on learners

22. The Government has implemented a national three-tiered COVID-19 alert level system in an effort to tackle the rising COVID-19 infection levels and to simplify the existing patchwork of regional restrictions. The definitions and implications of the COVID-19 alert system are summarised as follows:

Tier 1- Medium	Tier 2 - High	Tier 3 - Very high
• Defined by fewer than 100 cases per 100,000 of population. • Baseline, minimum restrictions apply. • This means nationwide restrictions including rule of six and 10pm curfew for hospitality venues apply.	• Defined by cases above 100 per 100,000. • Triggered when rise in transmission cannot be contain through local response. • This means in addition to tier 1 restrictions, no households are allowed to mix indoors, rule of six applies outdoors, including private gardens.	• Defined by significantly higher rates of transmission. • Triggered when Tier 2 measures have not contained the virus or where there has been significant rise in transmission. • This means in addition to tier 1 restrictions, no households are allowed to mix indoors or outdoors, people are advised against travel in and out of area, all pubs/bars close unless they can operate as a restaurant.
• *However, as part of formal education and training students/trainees can meet in groups of more than 6 and wherever possible should socially distance from people they don't live with.*	• *However, students can move home and travel to go to university, but they must not move backward and forward between permanent home and term time address during term time.*	• *However, for educational purposes students can move home and travel to go to university, but they must not move backward and forward between permanent home and term time address during term time.*

Implications for healthcare students

23. The Department for Education has published guidance for providers of higher education on re-opening buildings and campuses. This confirms Higher Education Institutions (HEIs) will remain open and students will be able to continue their education and training; and education providers operate their teaching provision **through a four-tiered** restriction system:

- Tier 1 (default position): Higher Education Institutions (HEIs) are expected to provide blended learning, with face-to-face tuition, following the provisions of this guidance, and public health guidance, including, for example, the appropriate use of face coverings.

- Tier 2 (fallback position): HEIs should move to an increased level of online learning where possible. Providers should prioritise the continuation of face-to-face provision based on their own risk assessment. We expect that, in the majority of cases, this will be for those courses where it is most beneficial (e.g. clinical or practical learning and research).

- Tier 3 (where stricter measures are needed): HEI providers should increase the level of online learning to retain face-to-face provision for priority courses (for example, clinical and medical courses), and in as limited a number of situations as possible. Students should follow government guidance published as part of any additional restrictions applied locally, including where this says that students should remain in their current accommodation and not return their family home or other residential accommodation to reduce the risk of transmitting the virus through travel. In these circumstances, providers should support students to do so by keeping services for students, such as university libraries and catering facilities, open

- Tier 4 (last resort in the event of a full scale lockdown): We expect the majority of provision to be online, with buildings open for essential workers only. This should include the continuation of essential research.

24. The DfE guidance and four tiered system for providers of higher education can be accessed here: https://www.gov.uk/government/publications/higher-education-reopening-buildings-and-campuses/higher-education-reopening-buildings-and-campuses#staff-and-student-wellbeing

25. Local health and social care services will work with providers to respond to future waves of COVID-19 infection and local scenario plan for the new three tier alert system. It is conceivable that particularly at Tier-3 student placements could be affected but HEIs and placement providers will aim to keep arrangements as normal as possible for students. Healthcare students are considered to be essential workers. This means that students should be able to access childcare for school age children during a lockdown and travel to placements. The current distribution of alert levels across England are highlighted in Table 1. All areas in England are medium, apart from:

Local COVID alert level: high	Local COVID alert level: very high
• Berkshire • Cheshire • Cumbria • Derbyshire • Durham • Essex • Leicestershire • London • Northumberland • Nottinghamshire • North Yorkshire • Staffordshire • Surrey • Tees Valley • Tyne and Wear • West Midlands • West Yorkshire	• Greater Manchester • Lancashire • Liverpool City Region • South Yorkshire

Table 1 - COVID-19 High and very high alert levels in England as of Tuesday 27th October 2020. Please note, some counties have partial geographical alerts in place – for specific locations within each affected local area, visit: https://www.gov.uk/guidance/full-list-of-local-covid-alert-levels-by-area

26. Student safety and well-being is paramount for universities and placement providers and risk assessments are in place to assess healthcare students before they commence placements. These will be taken into account students moving from different areas of risk categories as well as the risk categories of the individuals themselves. The key principles of governance and reporting to HEE on the impact of COVID established during the initial lockdown will continue as HEE regional teams liaise with HEIs, placement providers and the regional NSHE&I teams to agree plans for placements and deployment for areas.

Fig. 1 Escalation Flow Diagram – non-medical and dental

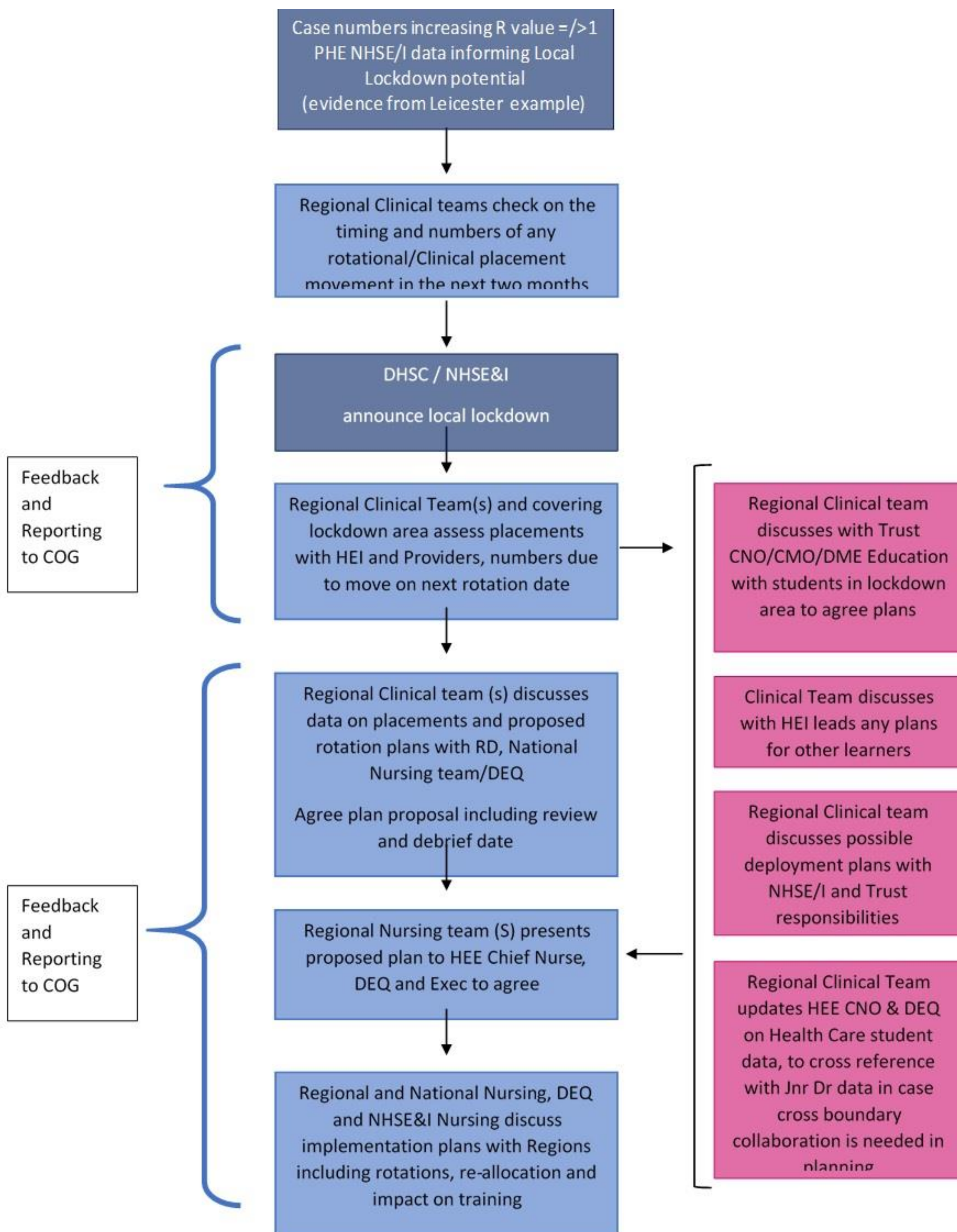
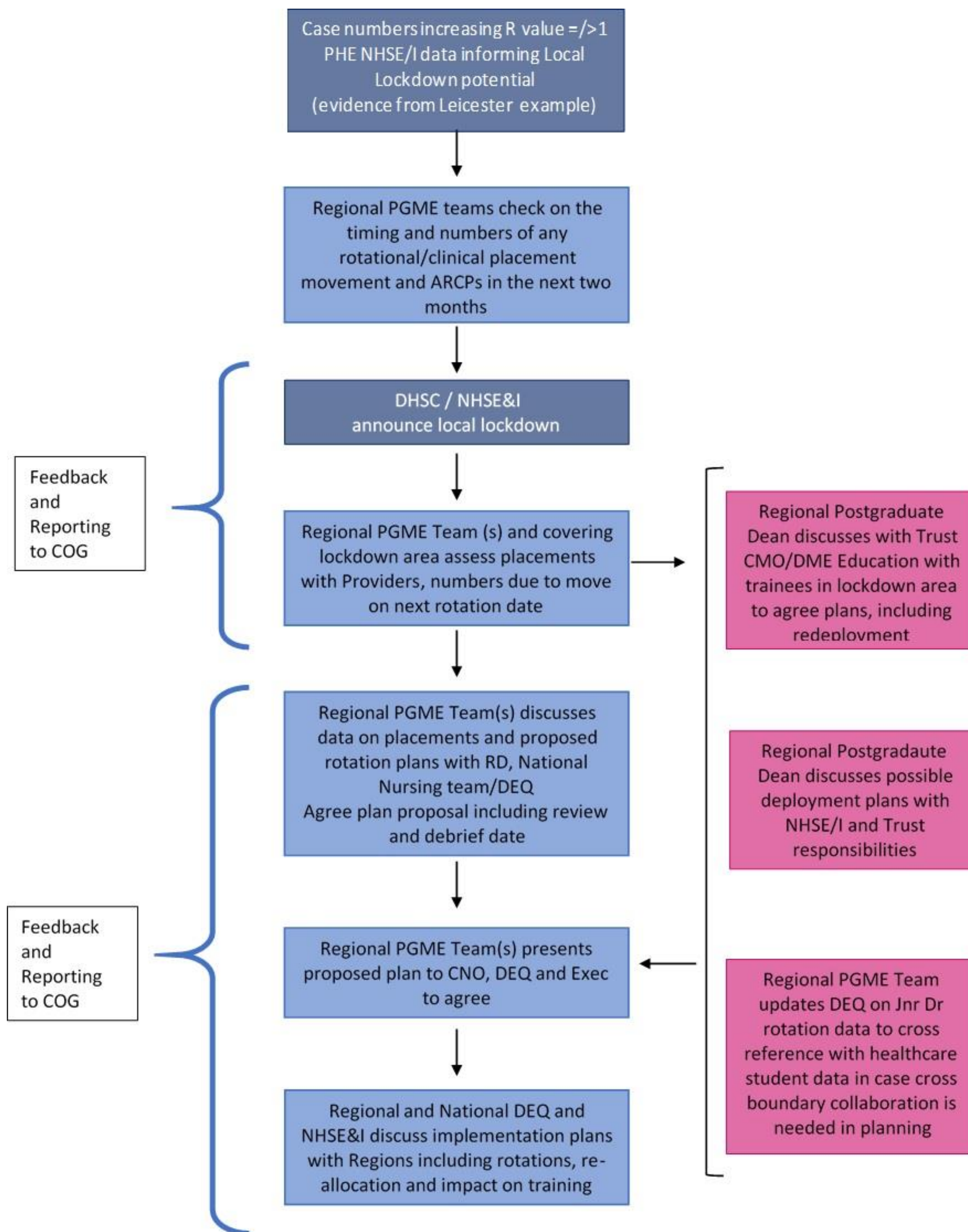


Figure 2: Escalation Flow Diagram – postgraduate medical and dental



5. LEGISLATIVE AND REGULATORY CHANGES TO INCREASE THE AVAILABLE WORKFORCE

Coronavirus Act 2020: Key changes to support deployment of the workforce

1. The Coronavirus Act 2020 received Royal Assent on 25 March, having been fast-tracked through Parliament in just four sitting days. The Act contains 'emergency powers' to enable public bodies to respond to the COVID-19 pandemic.

2. The purpose of the Coronavirus Act is to enable the Government to respond to an emergency situation and manage the effects of the COVID-19 pandemic. The Act contains temporary measures designed to either amend existing legislative provisions or introduce new statutory powers which are designed to mitigate these impacts.

3. The Act aims to support Government in doing the following:

    - Increasing the available health and social care workforce
    - Easing the burden on frontline staff
    - Containing and slowing the virus
    - Managing the deceased with respect and dignity
    - Supporting people

4. Section 98 of the Act obliges the Government to seek the House of Commons' agreement to the continued use of the emergency powers (that are not devolved) that are in force when each six-month review period falls due. Parliament voted to approve the motion to renew the provisions in the Act on 30 September by another six months. On the same date, the Secretary of State agreed a concession to consult parliament and allow MPs to vote on significant national measures which introduce lockdown restrictions.

Key provisions which are relevant for the training workforce:

- Increase workforce capacity: enabled regulators to open emergency registers for recently retired professionals without repercussion on their pensions, and students at the end of their training.
- Provide indemnity for clinical negligence liabilities arising from NHS activities carried out for the purposes of COVID-19. Applied to all staff, students, volunteers in any health and care setting.
- Enable existing mental health legislation powers to alter requirements for detaining and treating patients and allow expansion or removal of time limits to provide greater flexibility.
- Made changes to the Care Act 2014 in England and the Social Services and Wellbeing (Wales) Act 2014 to enable local authorities to prioritise the services they offer
- Lifted administrative requirements for early and quick discharge of patients, allowing greater focus on patients in most need.
- Introduced equivalent legal measures across the UK to delay and prevent the further transmission of the virus.
- Allowed volunteers in the NHS to pause their main job to care for patients, without employment ramifications.

Changes to professional regulation – temporary and provisional registration to mitigate against staff shortages and disruption to trainee progression

5. The emergency legislation in the form of the Coronavirus Act 2020 and the key provisions it enacted on temporary registration allowed HEE to deploy and redeploy the training workforce to support the NHS response to the first wave of the pandemic.

6. For the new academic year, HEE's current position is that all healthcare students and postgraduate trainees should continue their education and training and there are no current plans to implement national deployment/redeployment measures. This may change if the pandemic intensifies and there is a resurge.

Temporary and provisional registration

7. The emergency legislation allowed the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) temporarily register fit, proper and suitably experienced professionals who want to practise and felt able to support the COVID-19 emergency situation. The General Medical Council (GMC) and the General Pharmaceutical Council (GPhC) already have these powers.

8. Only four of the nine professional healthcare regulators – NMC, HCPC, GMC, GPhC - operated temporary registers for experienced or suitably qualified professionals to return to practice. Only three offered temporary/provisional registers for students: HCPC, GMC, GPhC.

Medical students and medical professionals

9. The GMC opened a temporary register for qualified doctors without a licence to return to practice and a provisional register for 5th year medical students who graduated early in May/June 2020. This resulted in:

   - Provisional registration of over 5,500 medical graduates to enable them to apply for interim Foundation Year 1 posts with the UK Foundation Programme Office[4].
   - Temporary registration of:
     - 15,500 doctors who had given up their registration or licence to practise within the last three years
     - nearly 6,800 doctors with a UK address who gave up their registration between three and six years ago
     - a further 12,000 doctors with a UK address who are GMC registered, but who do not currently hold a licence to practise.

GMC's current approach to provisional registration

10. Currently, the GMC is processing applications differently to the process adopted in May to July 2020 for the 2019/20 medical graduate cohort. Once medical graduates have submitted their application, the GMC will be in touch directly with further information on next steps. The GMC has no plans to open a provisional register for the 2020/21 Year 5 medical cohort during the autumn/winter term of 2020 given that they are required to complete a year of learning.

GMC's current approach to temporary registration

11. Temporary registration will last for the duration of the emergency. Section 18A of the Medical Act 1983 sets out that the Registrar must remove temporary registration when the Secretary of State advises the Registrar that the circumstances that led to the declaration of the emergency no longer exist; and may remove it for any other reason, including where the Registrar suspects that a person's fitness to practise may be impaired. Further information on the GMC's policy can be accessed here: https://www.gmc-uk.org/-/media/documents/policy---removal-of-temporarily-registered-medical-practitioners-under-s18a-of-the-medical--82625554.pdf

[4] file:///C:/Users/Samina.Malik/Downloads/2020%20Recruitment%20Stats%20and%20Facts%20Report_FINAL.pdf

Nursing and Midwifery students

12. The NMC did not operate a temporary register for nursing students. However, at the start of the pandemic, the NMC introduced a set of emergency standards to:

    - enable student nurses and midwives in the final six months of their programme to complete their training in appropriate placement settings
    - give education institutions and their practice learning partners more flexibility to ensure students get appropriate support and supervision
    - enable students to use their knowledge and skills appropriately during this time of crisis to support the care of people

13. With the pandemic continuing, the NMC withdrew the majority of the emergency standards on 30 September 2020 to support students returning to their normal studies and supernumerary placements. As the standards are facilitative rather than directive, Approved Education Institutions (AEIs) can choose to return to normal ahead of that date.

14. The NMC has replaced the emergency standards with a set of recovery standards. These recovery standards enable flexibility and support HEIs in the move towards a more normal delivery of programmes and practice learning to ensure students receive appropriate support and supervision. AEIs and their practice learning partners will be regularly reviewing risks and communicating any impact this might have on their students to the NMC. Further information on NMC's approach to continued regulation during the pandemic can be accessed here: https://www.nmc.org.uk/news/coronavirus/information-for-students-and-educators/

Students of Allied Health Profession Programmes

15. On 17 March 2020, in response to the COVID-19 pandemic, the HCPC published a COVID-19-temporary register, of two parts to ensure there were no regulatory barriers to the following two groups practising on a temporary basis:

    - Former registrants who had de-registered within the last three years.
    - Final year students, on UK approved programmes, who had completed all their work-based learning requirements

16. As the UK moves through the COVID-19 emergency period, HCPC continues to engage with the sector to inform its understanding of workforce requirements. It has stated that the temporary register will remain in place only for as long as is necessary to manage the emergency response to the COVID-19-19 pandemic and would seek to close the temporary register once the UK has passed through that period; and any risk of a resurge phase has dissipated.

Pharmacy students and pharmacists returning to practice

Temporary registration

17. The GPhC used its statutory powers under the Pharmacy Order 2010 to register on a temporary basis fit, proper and suitably experienced people to act as pharmacists and pharmacy technicians as part of the COVID-19 emergency declared by the Secretary of State.

18. The temporary register includes pharmacy professionals who had voluntarily removed themselves or were removed for non-renewal from the GPhC register in the last three years and did not have Fitness to Practise issues. The temporary register will remain open until the Secretary of State declares the emergency period has ended.

Provisional registration

19. Pre-registration trainees can apply to join the GPhC provisional register until July 2021, provided they meet a set of criteria. In order to remain on the GPhC register, they must sit and pass the registration assessment “at the first opportunity if they are fit to do so”. The GPhC policy sets out criteria for applying to provisionally register as a pharmacist apply from 1 July 2020 until 1 July 2021.

20. The criteria include; successfully completing 52 weeks pre-registration training, not having previously failed the registration assessment and having received a final declaration from their tutor confirming that they have met all the performance standards and are safe to be registered provisionally.

21. All provisionally registered pharmacists will have to be employed directly by the organisation or business in which they are working (and so cannot work as a locum) and must practise under the guidance and direction of a senior pharmacist. The policy confirms they may operate as the Responsible Pharmacist.

22. The GPhC has confirmed it has identified a preferred supplier for the online registration assessment and is currently in contractual discussions with them. They are intending to hold the registration assessment in the first quarter of 2021, while avoiding the first two weeks of January. Further information and guidance can be accessed here: https://www.pharmacyregulation.org/registers/provisional-registration-pharmacists

Professional Indemnity

23. In recognition that there will be a need for changes to working arrangements during COVID-19 emergency period the Coronavirus Act 2020 provides the Secretary of State for Health and Social Care with powers to provide indemnity for clinical negligence liabilities arising from NHS activities carried out for the purposes of dealing with, or in consequence of, the coronavirus outbreak, where there is no existing indemnity arrangement in place (section 11 of the Act).

24. The Government introduced the additional indemnity cover under the new Act for clinical negligence liabilities that arise when healthcare professionals and others are working as part of the Coronavirus response, or undertaking NHS work to backfill others as a consequence, and existing arrangements (CNST, CNSGP or individual arrangements) do not cover a particular activity. This additional indemnity cover will provide an additional safeguard and is complementary to any existing indemnity provision already in place.

25. The additional indemnity provided by the Coronavirus Act 2020 covers NHS services commissioned from non-NHS providers. These arrangements will therefore include healthcare professionals and others from the independent sector, working as part of the Coronavirus response, where there is no existing indemnity arrangement in place.

26. The professional regulators and the four Chief Medical Officers1 have set out guidance to reassure those working for the NHS that where they need to work in different ways, that they should be supported to do so; that the regulators will take extreme circumstances into account; and that the usual regulatory frameworks and the need to act in line with the principles of good practice set out by the regulators will apply.

27. Healthcare professionals and others carrying out NHS activities will continue to be covered for clinical negligence incidents if they have to work in different ways or locations – for example, advising more patients over the telephone instead of in face to face appointments or working in different settings.

28. Where volunteers are asked by NHS trusts to help deliver NHS services, and a volunteer agreement is in place between the trust and the volunteer or volunteer organisation, then indemnity for clinical negligence will be provided under the CNST.

29. Medico-legal cover is not part of the CNSC arrangements. The Government's intention is that access to medicolegal support should not be a barrier for people to return to practice. Medical and Dental Defence Union of Scotland (MDDUS), Medical Defence Union (MDU), and Medical Protection Society (MPS) have confirmed that they will provide medico-legal advice and support at no cost to their retired members who return to work on the COVID-19 response.

    For further information see NHS Resolution's website: https://resolution.nhs.uk/2020/03/19/COVID-19-19-and-business-continuity/

Changes to Human Medicines Regulations

30. The UK Government, with the Minister of Health in Northern Ireland, ran a 3- week consultation in September 2020 seeking views on proposed changes to the Human Medicine Regulations 2012. The consultation covered:

    - authorising temporary supply of an unlicensed but tested COVID-19 vaccine
    - civil liability and immunity
    - expanding the workforce eligible to administer vaccinations by expanding the scope of patient group directions (PGDs) to allow the administration of any medicine, including COVID-19-19 vaccines, the supply of which has been temporarily authorised under regulation 174 of the Human Medicines Regulations (HMR).
    - promoting vaccines
    - making provisions for wholesale dealing of vaccines

31. The proposals consulted on suggested ways to improve access and ensure as many people are protected from COVID-19 and flu as possible without sacrificing the absolute need to ensure that any vaccine used is both safe and effective. The draft Statutory Instrument (SI) amending the HMR was published alongside the consultation.

32. The Department of Health and Social Care (DHSC) published its response to the consultation on 16 October and laid the Statutory Instrument before Parliament on the same date. The amendments to the Regulations allow for other specified categories of registered health care professionals to administer coronavirus and influenza immunisations as part of the occupational health schemes of local authorities and specified NHS bodies. These arrangements are time limited to 1st April 2022 (regulations 3, 12 and 32). The DHSC's response states national protocols would be created in each country of the UK to determine who could administer any COVID-19 or flu vaccine and these should include requirements for supervision by an additional experienced vaccinator for healthcare staff newly qualified to administer vaccines.

33. A comprehensive training package is being put together by NHS England and NHS Improvement (NHSE-I), with professional groups and Public Health England (PHE). New vaccinators will have to undergo both a comprehensive training programme and competency assessment to ensure they can safely administer vaccines to patients under the clinical supervision of an experienced health care professional. This training will include how to deal with possible adverse reactions to a vaccine. HEE will confirm what this training means for postgraduate medical and dental trainees once it has received further detail from the NHSE&I team.

34. The DHSC's response did not specify which additional categories of healthcare professionals would be newly able to provide vaccinations. This will be decided in each of the UK's countries. This guidance will be updated with further details on which additional categories of professions can provide vaccinations once these have been confirmed by the DHSC and NHSE&I.

Visa extensions for healthcare workers

35. As part of the national effort to combat coronavirus, the Home Office announced automatic one year extensions to Tier 2 visas for the following regulated professions working in the NHS and independent sector:

- biochemist
- biological scientist
- dental practitioner
- health professional
- medical practitioner
- medical radiographer
- midwife
- nurse
- occupational therapist
- ophthalmologist
- paramedic
- pharmacist
- physiotherapist
- podiatrist
- psychologist
- social worker
- speech and language therapist
- therapy professional

36. The one-year extension comes into effect immediately and is for all visas expiring between 31 March and 1 October 2020. Those benefitting from this extension will be identified by health and care employers across the UK.

37. The Government also confirmed that family members and dependants of healthcare workers, who sadly pass away as a result of contracting the virus, will be offered immediate indefinite leave to remain.

38. The extensions are exempt from UK visa fees and Immigration Health Surcharge fees.

39. The Home Office recently confirmed that workers with visas due to expire after 1 October 2020 will not get the free extension and will need to extend their visa in the normal way. Further information can be found on the UK Visa and Immigration website: https://www.gov.uk/coronavirus-health-worker-visa-extension

6. APPRENTICESHIPS

Changes to apprenticeship guidelines

1. The Department for Education (DfE) continues to closely monitor the impact of the COVID-19 outbreak on apprenticeships. Social distancing measures have created some challenges for apprentices, employers, training providers and assessment organisations.

2. During the first wave of COVID-19, employers had to maximise the number of staff available to support the NHS response to the pandemic and apprentices on healthcare apprenticeships may have been asked to move into a different role.

3. A number of flexibilities have been introduced to support employers, apprentices and training providers during the pandemic, so that apprentices can continue learning and complete their apprenticeship. These include promoting the remote delivery of training and assessment and allowing apprentices who have been furloughed to continue their off-the-job training.

4. Among the flexibilities announced regarding end-point assessments (EPA), these include allowing remote assessments where practical and possible, or delaying the EPA where appropriate. The Institute for Apprenticeships and Technical Education (IfATE) has also introduced temporary discretions to the End Point Assessment for over 100 apprenticeship standards which include a number of exceptional flexibilities for specific apprenticeships.

5. The IfATE has also agreed flexibilities in the way apprentices can achieve the observation element of their EPA during the COVID-19 crisis for the following apprenticeships:

    - Healthcare Support Worker - Level 2
    - Senior Healthcare Support Worker - Level 3
    - Assistant Practitioner - Level 5

    Until further notice, the observation assessment may be replaced with a reflective statement written by the apprentice and validated by an expert witness. This will be followed by a question and answer session of up to 30 minutes with an independent assessor.

6. The Government has announced steps to allow workers, including apprentices, to begin returning to work where it is safe to do so, and in line with the safer working guidance: https://www.gov.uk/government/publications/our-plan-to-rebuild-the-uk-governments-COVID-19-19-recovery-strategy. Employers, providers and apprentices should continue to mutually agree where and how training takes place.

7. Where it is not possible to continue training or assessment due to COVID-19, the DfE has enabled apprentices, employers and providers to initiate a break in learning, to ensure that apprentices can continue and complete their apprenticeships when it is possible to do so.

8. Latest guidance published by the Education, Skills and Funding Agency (ESFA) on the support available for apprentices, employers and training providers is set out here: https://www.gov.uk/government/publications/coronavirus-COVID-19-19-apprenticeship-programme-response/coronavirus-COVID-19-19-guidance-for-apprentices-employers-training-providers-end-point-assessment-organisations-and-external-quality-assurance-pro.

    This guidance recognises where apprentices can remain on their programme, they should continue to fulfil the 20 per cent off-the-job training element. Where an NHS apprentice (critical worker) has been redeployed into another role, then some of this activity may count towards their off-the-job training. This should be discussed and agreed between the employer and provider and evidence of delivery must be kept. The ESFA continue to keep this guidance under review.

9. In the majority of cases, pay will not change as the work the apprentice would be doing is of the same level. Where work is of a different level, then the appropriate rate for the job should be paid.

10. The Nursing and Midwifery Council (NMC) has updated its guidance on apprenticeship standards and end point assessments for nursing and midwifery apprenticeships and nursing associate apprenticeships. This can be accessed here: https://www.nmc.org.uk/news/coronavirus/information-for-students-and-educators/

11. For registered nurse and nursing associate apprenticeship programmes changes have been made to the EPA that reflect the emergency standards introduced by the Nursing and Midwifery Council (NMC). Any registered nurse and nursing associate apprentice will be regarded as having met the EPA requirements and achieved their apprenticeship, if they have:

    - completed the NMC approved programme
    - been assessed by the NMC as having permanently met the requirements for professional registration
    - passed through the apprenticeship gateway.

12. For healthcare apprenticeships, the Healthcare Apprenticeship Standards Online (HASO) has a COVID-19 hub which is regularly updated on changes to apprenticeship rules and guidelines. This can be accessed here: https://haso.skillsforhealth.org.uk/faq-category/coronavirus-COVID-19-19/

7. HEE QUALITY VISTS

1. HEE paused all routine healthcare education quality activities during the first wave of the COVID-19 pandemic but committed to continue supporting existing critical quality concerns. Alongside this, with pressure on the health and care system requiring some learners and trainees to work outside of their usual training pathway and/or contracted duties, HEE developed a set of principles to ensure their welfare so that they could continue to practise safely, were not exposed to risk and patient safety was maintained.

2. To continue to monitor the quality of education and training during this time, and to be assured of patient and learner safety, HEE collected trainee and learner feedback at a national level through targeted online surveys and virtual focus groups. Locally, quality teams adapted their practices in a flexible, innovative and agile way to effectively quality assure and quality manage clinical learning environments. This included the use of virtual technology in place of face-to-face quality meetings, strengthening relationships with key stakeholders, capitalising on a broader range of data sources, utilising existing forums to focus on quality, and supporting local educators with their continued focus on quality 'on-the-ground'. This enabled 'local-to-national' escalation and reporting of quality issues to continue (for example, in line with HEE's Intensive Support Framework and the Quality Risk Register).

3. HEE will deliver its core quality function during the next COVID-19 surge (and compounding winter pressures) by taking forward the lessons learned during the first wave, developing and building on the innovative approaches to quality and continuing to re-start existing activities, which had previously been paused during full lockdown. This will be done with strict adherence to local and national COVID-19 rules and policies. Further detailed guidance is being created for local and regional teams to ensure consistency and promote best practice while recognising the need for local flexibility and decision-making. The key principles set out HEEs expectations during this and subsequent COVID-19 surges to ensure learner and patient safety.

4. Nationally, HEE will progress with its data and intelligence collection and analysis through the scheduled November launch of its National Education and Training Survey (NETS), and via information sharing with regulators and other system partners. Moreover, HEE will undertake additional, focussed quality monitoring where required (for example, through further targeted surveys and focus groups), with an emphasis on learner and trainee wellbeing and safety.

8. HEALTHCARE EDUCATION FUNDING AND TARIFF ADMINISTRATION

Funding approach to date

1. At the outbreak of the pandemic, HEE committed to continue to make payments in support of the education and training delivered by its partners.
2. HEE made block payments to NHS Trusts to cover the period of March to August inclusive (except postgraduate medical and dental, where activity payments started again in August).
3. These block payments will be retrospectively adjusted, with the exception of: tariff and tariff related activity, salary support payments and non-tariff HEE postgraduate funding (such as palliative care, public health, etc). For these 'exceptions', the payment amount was based on 2019/20 payments and was provided as a fixed amount to cover activity through this period. This helped provide certainty and financial stability to our partners.
4. Where payments to NHS services are provided by Medical Schools on HEE's behalf, HEE provided funding and requested that Medical Schools make their payments as planned, again to ensure stability and the preservation of placement capacity. HEE's payments to Dental Schools were undisturbed through this period and Dental Schools received the expected funding.

Current funding approach

5. Activity driven payments have fully resumed, with full reconciliation to actual activity from 1st September.
6. All payments from September onwards will be reflective of actual placement activity, and this includes any placement activity delivered from September as a result of growth in student numbers (medical and clinical), or 'catch-up' activity for students impacted by COVID restrictions. As Dental Schools do not follow 'activity driven payment' processes, they are not included in this approach, and the funding package for undergraduate dental students is the same as expected at the start of the financial year.
7. Education & Training Tariff payments covering 1st April onwards will now be updated (increased) to include the new 2020/21 tariff rates, but 2019/20 activity data will still be used for the period April - September.
8. Activity driven payments are now, and will continue to be, HEE's default funding approach as we continue to support providers through the pandemic response.
9. All eligible education and training activity will be funded from September; however, we cannot make any retrospective payments for activity delivered prior to September where this was not agreed in writing with HEE in advance.
10. If an education or training partner feels there is a payment due to them as a result of placement activity prior to September, and this was based on a local agreement with an NHS Trust, then this should be agreed locally with any transfer of funding aligned with current DHSC guidance on placement activity.

Further detail

Quarter 1 (2020/21)

11. In March, HEE's Director of Finance wrote to all NHS Trusts and Medical Schools to notify them that HEE would be making a fixed three-month Quarter 1 (2020/21) payment to them on account; calculated as 25% of the value of their 2019/2020 payment from HEE.

12. This block payment will be retrospectively adjusted to take in account any activity data submitted to HEE, however there are exceptions to this. These exceptions are:

- Tariff and tariff related activity;
- Salary support payments;
- Non-tariff HEE postgraduate funding (such as palliative care, public health etc).

13. All other Learning & Development Agreement (LDA) payments, such as workforce development, will be retrospectively adjusted to account for actual activity.

14. 2019/20 Education & Training Tariff funding rates were used for the tariff element of this payment (as the 2020/21 Tariff Guidance was yet to be published), and the payment reached all NHS Trusts before 15th April 2020.

July 2020/21

15. HEE made a further payment on account to cover July 2020, on the same terms as the April payment (a retrospective adjustment with the exception of the three areas outlined above).

16. However, this payment excluded Continuous Professional Development (CPD) funding, as CPD funding paid in the first quarter covered the first six months of the financial year. Trusts/service providers did not need to raise an invoice for the July 2020 payment, and the payment should have been received by Trusts/service providers before 15 July 2020.

August 2020 onwards

17. Activity driven payments for postgraduate medical and dental began again in August, to coincide with the new post rotations.

18. For all other activity driven payments, these were again paid on account for August (on the same terms as the previous payments).

19. From 1st August, NHS Trusts returned to the normal practice of invoicing HEE, with the first invoice covering August – October 2020.

20. Activity driven payments restarted completely at the start of September and all payments including tariff, salary support and non-tariff PG funding will be reconciled with ‘actuals’ data from this point onwards.

Providing activity data to HEE

21. The activity data that HEE collects through its data collection processes helps HEE to reconcile financial payments for education and training services. With some adjustment, the HEE data collection processes continued through the peak of the pandemic and this remains an important record of activity, both for year-on-year comparisons and to help with workforce planning/future financial forecasting.

22. However, in line with the approach above, the data collected relating to March 2020 to August 2020 will not be used to reconcile the Education and Training tariff payments already made for these months.

23. Tariff payments covering up to 31st August 2020 will remain fixed, using 2019/20 data and will be not be retrospectively adjusted for any ‘actuals’ data submitted through the Student Data Collection, the HEI Undergraduate Medical activity data returns and the Trainee Information System. However, the tariff element of any 2020/21 financial year block payment (tariff payments covering April onwards) will be adjusted upwards to apply any increase in rates announced in August’s new DHSC 2020/21 Tariff guidance and the interim tariff for Undergraduate Medical placements in General Practice (from the point at which placement activity resumes).

9. EDUCATION MANAGEMENT FOR STUDENTS AND THE TRAINING WORKFORCE

Medicine

Undergraduate

1. As medical students are commencing the academic year, and final exams have not been undertaken, it will not be possible for students to graduate early and enter the clinical workforce as provisional registrants. Furthermore, HEE has committed not to redeploy students from their scheduled clinical settings. As noted in section 5 of this guidance, the General Medical Council has no plans for operating a provisional register for final year medical students as redeployment is currently not required given that these students are at the beginning of their final year term.
2. Where students have scheduled placements in intensive care settings, the Adult Critical Care (ACC) staffing framework recommends that medical students can fill bedside support workers roles in ACC settings. Medical students can also perform a range of duties and procedures including taking blood, talking to relatives of patients in critical care and supporting A&E receptions.
3. The Medical Schools Council has a dedicated webpage updating students on restarting clinical placements, this can be accessed here: https://www.medschools.ac.uk/COVID-19-19/information-for-medical-students

Postgraduate Medical Education

Recruitment into Foundation Training

4. The UK Foundation Programme Office (UKFPO) has responsibility for the delivery of recruitment to the Foundation Programme and Academic Foundation Programme and curriculum delivery.
5. Recruitment into the foundation programme is an allocation process which is due to take place on 22nd March 2021. There are no interviews as part of the foundation selection although applicants will sit a Situational Judgement Test (SJT) that is delivered online or at test centres.
6. Detailed timeline and information can be found at https://foundationprogramme.nhs.uk/

Recruitment into Specialty Training

7. Through the Medical and Dental Selection and Recruitment Programme (MDRS), HEE leads the delivery of postgraduate medical and dental recruitment on behalf of the UK health departments. The recruitment process involves over 80 different training programmes with 40,000 applicants for 13,000 vacancies each year.
8. The 2020 recruitment process was impacted due to the COVID-19 pandemic, which caused the development of contingency plans. The contingency plans removed the interviews/selection centres and replaced with online testing and trainee self-assessment scoring.
9. The MDRS programme has been working with lead recruiters and specialties to develop plans for 2021 recruitment, which can be delivered in case of a resurge but also take into consideration applicant and panel member feedback around the desire for face to face interviews.
10. Each specialty will be required to submit two recruitment plans.

    - **Plan A** – Preferred delivery model of recruitment based on the above agreed principles and the known delivery constraints.
    - **Plan B** – How recruitment would be delivered if there was a significant 2nd peak of the pandemic which effects clinician or trainee availability or the availability of administrative support. Plan B should be deliverable without the need for clinicians.

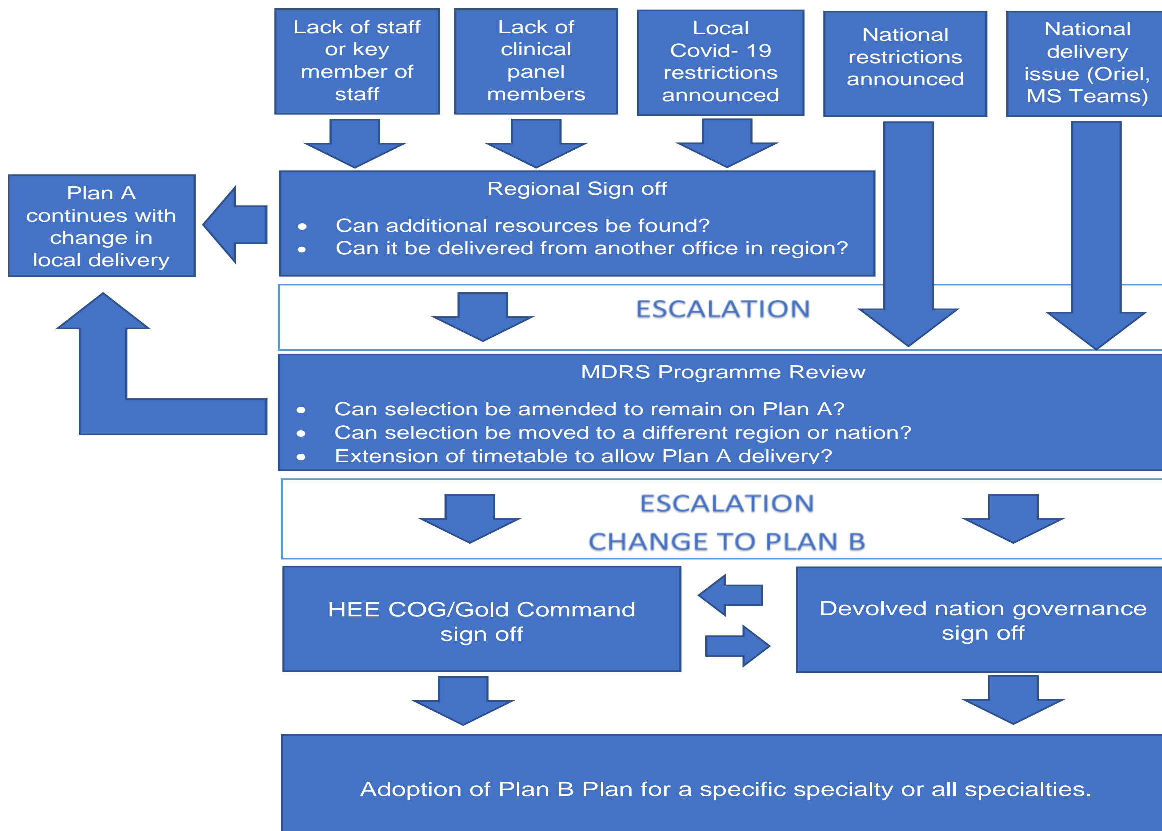
    If a specialty is unable support selection within online interviews and Plan A is not deliverable it may mean selection does not occur within this round of recruitment.

11. The following general principles for recruitment have also been agreed via the MDRS governance.

- Recruitment plans should be developed with the anticipation of further COVID disruption and therefore should be future proofed, meaning that they are deliverable regardless of social distancing or restrictions in place and will not need to be changed after applicants have applied
- Applicants should be aware of the selection process that they will undertake before they submit an application
- No in person face to face interviews throughout the 2021 recruitment process
- Where self-assessment is used, evidence should be verified, unless an exception has been agreed by the MDRS Board.
- Any interview processes should be undertaken digitally as a single panel and not as a multiple mini interview format.
- The interview panel should consist a minimum of two panel members, one of whom must be a consultant. This can be reduced to a single consultant if clinical pressures necessitate it.
- Consideration should be given to recording interviews with only one interview panel member.
- Lay representatives should be available to undertake quality assurance checks on a proportion of the interviews taking place
- Where applicant numbers exceed interview capacity, shortlisting processes can be adopted

12. To ensure delivery of the required interviews across all grades the specialty recruitment timetable has been adjusted to ensure the most efficient use of resources. The timeline can be accessed here: https://specialtytraining.hee.nhs.uk/Recruitment/Recruitment-timelines

13. The below flow diagram provides the escalation process if a specialty requires a significant change to their agreed Plan A or a move to their Plan B delivery.



Rotations

14. Our priorities are to protect the education and training of our future workforce, to enable junior doctors to ensure the continued delivery of healthcare services and to maintain the quality and safety of patient care during a winter period that is likely to be busier than usual.

15. Scheduled rotations should continue as planned wherever possible, particularly for foundation and core trainees. Regional flexibilities to rotation dates are permitted for higher trainees, with a view to balancing regional training and service needs. This flexibility will facilitate the provision of high quality training posts for trainees to rotate into and support resilience within the system.

16. Local and regional demand scenarios will allow the system to respond with appropriate interventions at transparent trigger points as the pandemic develops at different speeds in different places.

17. Training placements within a programme area may change due to changes to service models. Where this happens, they will still be in the same geographical area and where high-quality training can be assured.

18. We will be making the most of local knowledge and expertise and minimizing disruption to planned placements wherever possible. HEE offices can work with relevant colleagues locally to determine the pace and timing of rotational changes for existing trainees, facilitating discussions around geographical location, workload management and around induction.

19. HEE is working with the Devolved Nations, GMC and medical Royal Colleges to enable trainees to progress by increasing the flexibility within training programmes at critical progression points and at other transition points in training.

Examination, assessment and progression for specialty trainees

20. Where a COVID-19 surge necessitates further cancellations of face-to-face postgraduate specialty examinations, the HEE medical director and deputy medical directors will work with the General Medical Council, other Statutory Education Bodies (SEBs), and the Medical Royal Colleges to consider safe contingences for assessing competency. As with contingency planning during the first surge, trainee representatives will be actively involved in this process.

21. We will build on the learning from the first peak of the pandemic in the UK. During this period, Colleges were asked to identify special areas of practice which may not be needed for normal consultant practice and could be undertaken as post-CCT fellowships. Innovative approaches to evidencing experience and assessing competency were also employed.

22. All examination bodies have already been asked to produce contingency plans in the event that COVID-19 requires adjustment to current planning. The Academy of Medical Educators have agreed to maintain a list of exams and contingencies

Data Capture of Redeployment of medical and dental Trainees

23. A data collection exercise has been developed to capture trainee rotation and placements in consistency across the country. Postgraduate Deans or their nominated representatives will prospectively approve all changes affecting medical and dental trainees. This will include three broad categories:

    a. **Rotations-** When rotations are paused or trainees moved between Trusts e.g. GP back to Acute Trust, to a nightingale, or between Trusts.
    b. **Placements** - Placement changes within an LEP that have been in place for 24 hours or more e.g. moving from surgery to ITU.
    c. **Shielding/Self Isolating** - When an individual trainee is unable to continue in placement.

24. The capture of this data will allow for more accurate information on the number of trainees whose training progression may have been affected and the forecast of financial implications.

Postgraduate Medical Curricula

25. HEE will liaise with the Medical Royal Colleges through our postgraduate deans to facilitate the safe introduction of revised postgraduate curricula, under the GMC's *Excellence by Design* process. Demands on supervisor time due to the pandemic should not present a barrier to this transition, and HEE will support Colleges and Faculties to address any issues.

26. The new curricula take a holistic approach to assessment, rather than requiring trainees to demonstrate a set number of competencies. HEE is keen to support the transition; particularly as COVID-19 pressures will necessitate a holistic approach to supervision and competency demonstration.

ARCP and Progression

27. HEE will continue to work with the other Statutory Education Bodies and Professional Bodies to support evidence gathering, preparing and delivering ARCPs during the COVID-19 Pandemic.

28. As the COVID-19 pandemic continues to impact on training, COVID ARCP Outcomes might be required for some time. For this reason, approval for curriculum derogations have been extended. They will remain under review dependent upon the course and impact of the pandemic.

29. The use of the COVID Outcomes 10.1 and 10.2 and ARCP appeals will apply to ARCPs scheduled up to and including March 2021. There will be a further review of the situation in March 2021.

30. In response to uncertainty of COVID-19 and subsequent lockdowns ARCP Panels will not be face to face. Virtual panels will mean changes will not need to be made during the ARCP process in the event of further lockdown restriction and ensures consistency across all regions.

Supporting ARCP progression for trainees who have been isolating

31. When arriving at an Outcome, ARCP panels will take into account the impact of the COVID-19 pandemic, including a flexible approach to time-off due to illness or meeting isolation requirements, such as shielding. Where the acquisition of required capabilities has been delayed solely due to the impact of COVID-19, trainees should be enabled to progress to the next stage of training. In these instances, where a trainee is expected to achieve their outstanding competencies before their next ARCP, an extension to training will not therefore be necessary.

Evidencing Experience

32. Trainees who are redeployed to different specialties and clinical service areas to support the COVID-19 response are encouraged to follow HEE guidance on evidencing experience. The guidance offers a light touch approach that maps experience to the GMC General Professional Capabilities
33. HEE has developed a COVID-19 skills passport to help acknowledge additional skills that health professionals gained or contributed during the COVID-19 pandemic. An account of skills acquired can be summarised by trainees and added to their e-Portfolio, to cross-reference with curriculum competencies.

Less Than Full Time and Out of Programme Trainees

Managing Less Than Full Time (LTFT) Training

34. HEE supports the following principles to facilitate Less Than Full Time (LTFT) trainees into frontline service:
    - **LTFT trainees who would like to return on a full-time basis**: This should only be considered where appropriate in accordance with health and personal circumstances
    - **LTFT trainees who wish to increase their current working percentage:** This should only be considered where appropriate for the individual
    - **On return to business as usual:** Trainees will automatically have the right to reduce their current working percentage and resume their original LTFT working arrangements.
35. Trainees considering these options may want to speak to their Educational Supervisor or Training Programme Director in the first instance before contacting their Local Office and employing Local Education Provider (LEP) to formally confirm their intentions. If increased hours are not sustainable these can be returned to previous levels.
36. HEE will continue to both honour existing LTFT arrangements. New applications for LTFT will be reviewed in accordance with workforce pressures and need, as is required by the Gold Guide. As per HEE guidance issued in July 2020, LTFT Category 3 applications in Emergency Medicine, Paediatrics, and Obstetrics and Gynaecology remain open, with implementation timelines reinstated at local office discretion in accordance with the Code of Practice.

Management of Requests for Out of Programme (OOP)

37. During a resurge phase of the COVID-19 virus, HEE is currently unable to accommodate Out of Programme requests for Research (OOPR), Training (OOPT) or Experience (OOPE).
38. Trainees may request an Out of Programme Career Break (OOPC) in are extenuating experiences, where agreement has been reached with the Postgraduate Dean.
39. As part of our commitment to support trainees during and post COVID-19, HEE has extended our Out of Programme Pause (OOPP) initiative to postgraduate medical trainees across all specialties. Recognising the impact of the pandemic on trainee wellbeing, OOPP provides up to a 12-month break from training and the opportunity to gain competencies which may have been missed during the pandemic. Doctor’s experience and competences gained during an OOPP will be considered on return to their training programme.

General Practice

Placements

40. Following the initial flattening of the COVID-19 infection curve, HEE wrote to GP specialty trainees on 7th May 2020, advising that training should revert to the 7:3 model (seven clinical sessions and three educational sessions). Wherever possible during the potential COVID-19 resurge, this guidance should continue to be followed. Training has already been disrupted it is vital that the flow of newly qualified GPs continues in order to meet ongoing demand for primary care services. Wherever possible curriculum fulfilment and assessments should continue to enable GP Specialty Trainees to continue to qualify as GPs.
41. However, as determined by local and regional demand scenarios, GP specialty trainees may be asked to volunteer to support the pandemic response if a service need is identified by regional COVID-19 trigger points. This will normally be in the Primary Care response, such as in their own practice Hot Hubs and therefore would continue to support their learning.

42. During any future COVID-19 surge, GP specialty trainees still need to be supervised at all times while they are working clinically, and time should continue to be set aside for a debriefing on the week between GP trainee and supervisor. The supervisor for an individual session will often be the Educational or Clinical Supervisor themselves, but as before, this responsibility can be delegated by the ES/CS to another doctor in the training practice

43. In the context of circumstances and challenges of the COVID-19 pandemic, GP ST3 trainees may be permitted to work additional hours in out of hours settings, training practices, CCG hot hubs and/or the NHS111 service.

44. Detailed guidance on supervision and support for GP specialty trainees in GP placements during the COVID-19 emergency can be accessed here.

Principles for secondary care GP Specialty trainee redeployment in the event of a COVID-19 resurge

- Gold Command at NHSEI are in overall control of the regional response to the COVID-19-19 pandemic
- Each STP area has a workforce group consisting of the Primary Care Dean and GP Associate Postgraduate Dean responsible for that STP area with the DMEs from every Trust. Information and decisions from those workforce groups are fed back to the senior leadership team (SLT) at HEE
- Any workforce plan needs the approval of Gold Command

Placement Management During a Resurge

45. As we do not know when, or if, there will be a resurge phase of this pandemic and what the intensity of that phase might be, these are general principles. Where possible, trainees remain working in a familiar environment, be that an acute trust or a general practice placement. Across the region, we have a range of changeover dates depending upon whether the posts are 3, 4 or 6 months long. So, more specific decisions in relation to changeover dates will need to be made at the time. It is possible that national HEE may decide to freeze placement rotations again which is likely to have an impact on placement durations. Where possible though, we will take ST phases into account.

46. The following is a summary of planned placements should there be a COVID-19 resurge. This will be communicated to all GP specialty trainees as soon as possible. If there is a resurge phase and this plan needs to be enacted, all trainees and educators will be informed by email. It is possible that varying decisions will be made on a STP footprint depending upon individual workload activity.

ST3 GP Trainees

- All ST3 GP Specialty trainees will generally remain working in their current practice
- When a trainee is due to rotate into their ST3 GP placement during a resurge phase, they will continue to do so

ST2 GP Specialty Trainees – rotations and placements generally continue as far as possible

- This group of trainees are likely to have already been re-deployed during their ST1 phase. Where possible, their planned training posts and rotation should be maintained
- Where GP Specialty Trainees are working in a GP placement, they will generally remain in that placement until their changeover date
- Where GP Specialty Trainees are working in an ITP post, they will generally work full-time (or equivalent) in the GP placement of that ITP post until their changeover date
- Where GP Specialty Trainees are working in a speciality post related to Medicine or A&E, they will become part of the mega-rota, whilst that is needed, or until their changeover date

- Where trainees are working in speciality posts including Paediatrics, Obstetrics and Gynaecology and Psychiatry, they will generally remain in that placement until their changeover date
- GP Specialty Trainees in a palliative care placement will generally remain in that placement until their changeover date
- GP Specialty Trainees in a Public Health placement will generally move to work in their local acute trust and become part of the mega-rota, whilst that is needed, or until their changeover date

ST1 GP Specialty Trainees – rotations and placements more likely to be affected

- This group of trainees have generally not had their GP placements altered yet
- Where GP Specialty Trainees are currently working in a GP placement, they will generally remain in that placement until their changeover date or the resumption of rotations
- Where GP Specialty Trainees are working in an ITP post, they will generally work full-time (or equivalent) in the GP placement of that post until their changeover date or the resumption of rotations
- Where GP Specialty Trainees are currently working in any speciality placement in an acute hospital trust, they will generally remain in that trust. The Director of Medical Education (DME), working with the medical staffing department, will coordinate which department the trainee will be placed in. This could include becoming part of the medical mega-rota.
- Where GP Specialty Trainees are working in a mental health trust, they will generally remain working in that trust at whichever location/department advised by the DME and medical staffing
- GP Specialty Trainees in a palliative care placement will generally remain in that placement until their changeover date or the resumption of rotations
- GP Specialty Trainees in a Public Health placement will generally move to work in their local acute trust and will become part of the mega-rota whilst that is needed.

There are 2 groups of GP Specialty Trainees who may be affected more than others by potential changes to their placements

a. The suggested placements for each ST group are based on August start dates. We recognise that there are also trainees with other start dates, mostly February. If a resurge phase occurs this autumn, there will be trainees with a February start date who will be potentially affected by placement changes for a year, equivalent to a third of their overall training programme
b. Trainees on the ATCF pathway. Whilst they have a shortened 2.5year training programme, they are accrediting 6 months of prior experience. Overall, whilst their training duration is the same, their start date might have a greater impact on the training time spent in an actual GP Specialty training programme

These trainees will need to be considered on a case by case basis through discussion with their TPD and Associate Postgraduate Dean.

Short Term Re-Deployments for ST1/2 GP Specialty *Trainees – on an individual STP basis*

47. If a future wave of the pandemic happens, there is the potential for a peak of clinical activity, during which acute trusts may need additional clinician support to help staff surge centres or to provide general rota support to enable rest breaks and holidays for junior doctors already working in that trust. Therefore, GP Specialty trainees in GP placements may need to be re-deployed to their local acute trust for a short period of time to help with this work. This would happen on a STP basis, following a review by the STP workforce group and would be in the context of demand in Primary Care also. Such redeployment would be exceptional.
48. As ST2 GP Specialty trainees are likely to already have had their ST1 training phase affected by the first wave of the COVID-19 pandemic, this short-term re-deployment will be restricted, where possible, to GP Specialty trainees in the ST1 phase of training. Trainees should have a realistic expectation of the work they will be asked to do as well as some indication of potential time frames.

They also need assurance that this time will still count towards their training and that, wherever possible, we will re-balance their training as equitably as possible after the resurge wave of the pandemic has eased. This is likely to happen in their ST2 phase of training.

49. Experience of implementing this strategy in the first phase has informed the following suggested approach:

- All ST1 trainees in secondary care placements to be informed of this possibility as soon as possible with an explanation of the nature of the work that is likely to be needed from them. Appropriate COVID-19 training should take place at this time so that the trainees are prepared in advance
- An agreed workforce activity level that will trigger the request for this re-deployment. This activity level should be agreed and defined now with NHSEI and then made available to the HEE STP workforce groups
- Re-deployment request decision to be made at the HEE STP workforce group and then shared with the Head of School/Primary Care Dean and Postgraduate Dean with an agreed implementation timeline of at least 1 week. This STP workforce meeting should also include the relevant TPDs
- Email communication to be sent to all GP Specialty Trainees in secondary care placement and educators, via the appropriate local administrator/TPD, alerting them to the decision and giving them contact details for the trust personnel coordinating the re-deployment. This communication will include the potential end date, although it is recognised that this may need changing depending upon the duration of increased clinical need. This communication should also include the fact that this period will count towards their overall training time and that subsequent re-balancing will take place as equitably as possible
- Lead employer to be kept informed of all placement changes with appropriate exchange of information between the trust and lead employer to ensure salary details are correct. No trainee will be disadvantaged financially by a change in post
- TPDs will work towards re-balancing the overall training programme for trainees wherever possible

Assessment - MRCGP

50. To be awarded a CCT in General Practice, the RCGP curriculum requires trainees to pass two examinations – the Clinical Skills Assessment (CSA) and Applied Knowledge Test (AKT).

51. During the first surge of COVID-19, HEE worked with the RCGP, trainee representatives, the GMC, NHS England and the Devolved Administrations to agree flexible and innovative approaches to these examinations, allowing trainees to progress:

52. The AKT examination, which restarted in July, is a technologically enabled socially distanced assessment. The CSA has been replaced with other assessments - including digital clinics, and reflections via a new online ‘Recorded Clinical Assessment’.

53. These alternative approaches to assessment will continue to be available to GP Specialty Trainees during a COVID-19 resurge. It is vital that all possible steps are taken to enable assessments to continue and necessary adaptations should be made to support this.

Clinical Academic Trainees

54. Clinical academic trainees, both those in full-time research and those in posts combining clinical and academic training, e.g. clinical lecturers and academic clinical fellows, responded to the health emergency in large numbers by voluntarily returning to full-time clinical duties. Estimates suggested that over 1,500 academic trainees in England alone were deployed to clinical duties, representing over 90% of all trainees on the Integrated Academic Training (IAT) pathway. Similar responses were seen from those in Out Of Programme Research (OOPR) and across the four UK nations. Many have made exceptional contributions to service and/or to COVID-19 related research.

55. The UK Clinical Academic Training Forum (CATF) and COPMED have together established a working group (membership below) to bring together representatives of postgraduate training, research funders, medical and dental schools and others across the UK to agree high-level principles to support future decision making and to support a consistent approach across the United Kingdom. These principles are:

- All clinical academic trainees will benefit from a considered and co-ordinated approach to managing any potential disruption to their research and clinical training needs due to Coronavirus or a similar situation.
- All parties must undertake the discussions needed in a transparent manner, following a process for a return to clinical service agreed by the Postgraduate Deanery.
- It is emphasised that the return of academic trainees to support the clinical service is on a voluntary basis.
- Due consideration should be given to issues of equality, diversity and inclusion and, specifically, to health, shielding or caring issues relevant to individual trainees.
- Following a period of disruption trainees should be supported in their future planning and to make any adjustments to their academic and clinical education appropriate for their stage of training.

Actions for Postgraduate Deans and Training Programme Directors

- To provide oversight of the process, with the aim of balancing the optimal research and clinical outcomes for trainees against the need to support exceptional clinical service need
- To provide a framework for maximum flexibility for periods of academic/research training where possible
- The Postgraduate Dean, or nominated deputy, should have oversight of the process and be in discussion with training programme directors, directors of medical education and HEI leads to determine whether, when and where academic trainees who volunteer should be supported to return to clinical service. This will include consideration of their specific specialty, skills and level of experience and also the time needed to suspend their research without unnecessary loss of research resources
- All trainees will be allocated an educational supervisor and receive any required skills training during their clinical placement

At the end of the emergency period the Postgraduate Dean will ensure that clinical academic trainees are returned to research training in a timely way, bearing in mind research training capacity in universities as well as any exceptional ongoing service need.

National Institute for Health Research

56. The National Institute for Health Research (NIHR) has recently published guidance which states that research staff funded by NIHR should not be deployed to front line duties except in exceptional circumstances. This is in contrast to the 'first wave' when many staff from the NIHR's Local Clinical Research Networks and Clinical Research Facilities were deployed to the clinical front line in anticipation of heightened need.

57. The NIHR guidance on a COVID-19 resurge can be accessed here: https://www.nihr.ac.uk/documents/nihr-guidance-for-a-second-wave-of-covid-19-activity/25837

58. The Restart Framework published by the NIHR in May to support the restarting of research paused due to COVID-19 is unchanged. This provides a flexible structure for local decision-making and sets out study prioritisation levels with COVID-19 Urgent Public Health studies as the top priority. It also highlights the importance of non-COVID-19 studies where the research protocol includes an urgent treatment or intervention without which patients could come to harm.

Dentistry

Undergraduate

59. All undergraduate dental students will continue their academic learning, restart placements that were paused during the first wave and commence scheduled clinical placements as part of their programme. There are no plans for redeployment. Dental Schools Council and the Association of Dental Hospitals have published a new report outlining a set of guiding principles to support all UK and Irish dental hospitals and schools towards the safe return to educational placement provision within open plan clinics. This can be accessed here: https://www.dentalschoolscouncil.ac.uk/wp-content/uploads/2020/09/COVID-19-Planning-return-to-Open-Plan-Clinics-Guiding-Principles-to-mitigate-risk.pdf

Postgraduate Dental Training

Recruitment to Dental Foundation Training

60. Due to the COVID-19 and ongoing restrictions, COPDEND has decided to make changes to the DFT national recruitment system for this year in England, Wales and Northern Ireland. The main change is that the application process will consist of the Situational Judgement Test (SJT) only. Further information is on the COPDEND website, including some practice SJTs.

61. Redeployment of Dental Foundation trainees to other roles and workplaces across primary and secondary care will be approved by the Associate Postgraduate Dental Dean and Postgraduate Dental Dean and the employer of the trainee.

Core and specialty

62. HEE will work with employers of Dental Core and Speciality trainees to ensure that they can best support the pandemic surge. Trainees within 6 months of CCT, who have not yet received an Outcome 6, should, where possible, be supported to remain within curriculum aligned activity.

Review of Competence Progression

63. Outcome 6C may be retained for dental foundation trainees who have been unable to obtain all curriculum requirements due to the pandemic, but are safe to successfully exit the programme. In these cases, the outcome will outline the outstanding requirements and provide the dentists with a personal development plan for obtaining these competencies. The COVID-19 outcome 10 will remain an option to use for speciality and core training ARCP outcomes
64. Further guidance can be accessed here: https://www.hee.nhs.uk/coronavirus-information-trainees

Pharmacy

65. HEE, together with the Pharmacy Schools Council (PhSC), the SEBS for England, Scotland, and Wales, the Royal Pharmaceutical Society (RPharmS). Association for Pharmacy Technicians United Kingdom (APTUK) and the British Pharmaceutical Students' Association (BPSA) continue to work collaboratively to ensure support for pharmacy learners, trainees and the workforce.

MPharm

Assessment

66. To ensure current pharmacy students can progress through their educational programme, Schools of Pharmacy represented by the PhSC are working closely with the General Pharmaceutical Council (GPhC) to design and approve alternative end of year assessments, or to defer certain assessments. These include distance assessments and completed coursework assessments to progress undergraduate pharmacy students (MPharm 1 – 3) through the education pipeline. It will also allow fourth year students (MPharm 4) to graduate and begin their 5th year prior to registration. In doing so, the future supply of the pharmacy workforce will not be compromised.

Placements

67. Clinical visits will be a decision between the Schools of Pharmacy and their partners. These do not currently fall within HEE's remit as they are not HEE funded. However, reference to HEE's planning, guidance and framework will continue to inform our response.

Redeployment

68. To maintain future workforce supply, it is important that students' learning is not impacted by any redeployment into the workplace. Any decision to deploy into a pharmacy workplace is the decision of the individual student, and all of the risks associated with deployment, including but not limited to: disruption to study, completion of assessments and academic progression; physical and mental health and safety risks.

69. Where a student opts to be deployed into a work setting, the following principles are recommended:

- students undertake activities appropriate to their level of experience and training
- a full physical and mental health and safety risk assessment is conducted by the employer and appropriate mitigation is put in place
- there should be no impact on a students' ability to complete any current or upcoming assessments to progress their learning.

70. Joint guidance has been produced in relation to student deployment during the first wave: '*Facilitating deployment of pharmacy undergraduate students to support the pharmacy workforce*'. This was published during wave 1 of the pandemic and is subject to ongoing review. It should be noted that HEE has stood-down the Pharmacy section of the COVID-19 data tool and is not currently supporting deployment of pharmacy students to employers. The guidance can be found here:https://www.hee.nhs.uk/sites/default/files/documents/MPharm%20student%20deployment%20joint%20guidance%20FINAL.pdf

Pre-Registration Pharmacists (PRP)

Recruitment for 2021/22 cohort

71. The Pharmacy National Recruitment Office (PNRO), hosted by HEE London and Kent, Surrey and Sussex, manages recruitment into Pre-Registration Pharmacist training programmes across England and Wales. The recruitment handbook for 2021 was published in the summer of 2020.

72. As a result of COVID-19 there will be no Multiple Mini-Interviews (MMIs) in the recruitment process, and applicants will be assessed using only the Situational Judgement Test (SJT) and the Numeracy Test.

73. Ongoing government restrictions to face to face gatherings are planned to continue for the foreseeable future, and we have observed and learned from the rapid changes needing to be made across all specialty recruitment, approaching our conclusions on the basis of what we feel is the fairest and least onerous way for candidates to demonstrate their capabilities during these unique times.

74. The Pre-Registration Pharmacy assessment methods have undergone a thorough review to ensure that they comply with the following stipulations:

- The delivery process used must be robust and evidence-based
- The delivery process must be aligned to NHS and government advice on social distancing.
- The delivery process should be accessible to all applicants irrespective of which country they are in and whether travel restrictions are in place
- No new assessment methodology would be used. The delivery process may change, but the assessment methodology should remain similar to previous years
- Public safety must be at the forefront of any decision

75. The PNRO has with stakeholders including employers, the Pharmacy Schools Council, the BPSA, Health Education England Pharmacy Deans and senior leadership.

Progression and Assessment - 2020/21 cohort of HEE commissioned trainees

76. In the first COVID-19 wave, 2019/20 PRPs faced disruption and unprecedented pressures during the final quarter of their training year. At the time, the GPhC stated that they expected progress reviews to occur as expected. However, they clarified that any appraisals completed later than planned, did not automatically affect the eligibility of trainees to sit the registration assessment.

77. A COVID-19 resurge has the potential to disrupt the 13-week and 26 weeks progress review: Mid-November 2020 and Mid-February 2021. For the 2020/21 PRP cohort, HEE recommend referring to the relevant GPhC guidance on progress reviews for this cohort and the following to support trainees: *'review their progress with the performance standards against their plan at the start of the year'*. It should be noted that the majority of the trainees based in community pharmacy are funded through NSHE&I.

78. A key milestone of the pre -registration year is the registration assessment, the GPhC are currently resolving this for the 2019/20 cohort, with an online assessment under consideration for early 2021. The learnings from this transition are anticipated to be applied for the 2020/21 cohort.

HEE commissioned pre-registration trainee Pharmacy Technicians

79. This is a new education and learning pathway, with HEE contributing towards salary costs and apprenticeship levy paying the education costs to the providers. It is workplace based, requires the completion of 2 years of training, which leads to the Level 3 Diploma in the Principles and Practice for Pharmacy Technicians. This programme is dependent on apprenticeship funding, which includes requirement for ring fenced learning time. This qualification enables registration as a Pharmacy Technician with the GPhC.

80. Advice and support will be dependent on where the learner is in their education and training cycle. HEE has developed guidance and will actively monitor, working closely with the GPhC to ensure progress of learners is not hindered. The GPhC does not maintain a register of PTPT therefore tracking these trainees across the system therefore HEEs engagement is for those that are salary supported.

81. Accessing funding through the levy requires 0.2WTE in training, therefore pharmacy training leads in service require close liaison with their employer apprenticeship leads to ensure this is maintained. There are specific requirements in relation to breaks in learning and impact on the duration to complete apprenticeship funded qualifications, any changes to PTPT training must be taken on an informed basis by all parties involved.

Redeployment

82. To maintain future workforce supply, the preferred approach is to consider workforce skills mix across the existing employed workforce. HEE has developed guidance for the safe redeployment of pharmacy trainees, noting that their skills in the first instance maybe more aligned to stepping up to roles in their training base.

83. Pre-registration pharmacists (PRPs) and pre-registration trainee pharmacy technicians (PTPTs) who are considered for deployment to Nightingale Hospitals may be individuals who have volunteered and are progressing as expected through the course and can be redeployed to provide support that aligns to the identified learning outcomes, this is dependent on individual experience and acquired competencies.

Nursing and Midwifery

84. In a joint statement, the NMC and other professional regulators have formally acknowledged that during the coronavirus outbreak, healthcare professionals 'may need to depart from established procedures in order to care for patients and people using health and social care services' https://www.hcpc-uk.org/registrants/updates/2020/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus/.

85. For Undergraduate Nursing Students (across the four branches) movement into paid placements as seen in the first wave of COVID-19 will not be practical until the last six months of students' training programme. Earlier moves could also have significant consequences to chances of graduation and a shortfall in qualified doctors and nurses in August 2021 as well as a longer-term shortfall in workforce supply. HEE has therefore committed not to redeploy student nurses or midwives during a resurge, unless required by exceptional circumstances.

86. Furthermore, the NMC has phased out the majority of emergency standards for students from 30 September and instead have published new recovery standards to support students, education and training: https://www.nmc.org.uk/standards-for-education-and-training/emergency-education-standards/

Allied Health Profession Students

87. All students studying pre-registration Allied Health programmes will continue with their studies and remain on their programme. Their clinical placements will continue for as long as is feasibly possible where there is appropriate life assurance coverage within NHS commissioned services.

88. HEE is supporting a significant number of Higher Education Institutions (HEIs) and providers to develop simulation and virtual connection to placements such as outpatient sessions run by Skype where this is feasible. Learner health and wellbeing continues to be a top priority for all HEIs.

89. There are no plans to deploy students to into the NHS to support a resurge and HEE is working with HEIs and providers to work through the backlog of paused clinical placements and resume these to ensure all students affected by the first wave of the pandemic can complete the required clinical placement hours.

90. HEE colleagues will continue to work with the Council of Deans, NHS Employers, HCPC and the professional bodies to review the system and advise on the optimal arrangements for AHP students to attain clinical hours and progression.

Paramedic students

91. All students studying paramedic science will continue their studies and remain on their programmes. There are no plans to redeploy student paramedics to support a COVID-19 resurge and students will continue to focus on their academic studies and scheduled supernumerary placements. Across most HEIs, the paramedic science programme structure is largely unchanged although the delivery has been modified to incorporate blended learning.

Healthcare science

Recruitment

92. The national interviews for the Scientist Training Programme were impacted by COVID-19. In the event of a surge, the National School of Healthcare Science at HEE (NSHCS) will continue to use the successful process implemented from April 2020 onwards. The new process was validated by HEE's Gold Command and has been subject to independent review and scrutiny by an external consultancy.

93. The NSHCS process during COVID-19 pandemic resulted in the recruitment of over 411 STP trainees to the HCS Masters level programme (the best in the programme's history) and nearly 50 HSST trainees to the doctoral level HSST programme.

94. Recruitment process to be employed:

- Longlisting and shortlisting processes to differentiate meaningfully between applicants.
- Candidates ranked and allocated directly to employers for local video interview.
- Interviews subject to guidance produced by the NSHC, with observation of a sample by School staff and either lay representatives or Academy of Health care Science representatives.
- Use of a set of approved interview questions for each of the 32 specialties had
- The small number of in-service candidates (existing NHS employees) were admitted without interview, provided they met the qualification requirements and were endorsed by their employer.
- Use of online Interviews for the smaller number of applicants for the doctoral-level HSST; this will replicate the national interview event.
- Applicants are advised of the arrangements and given the right to withdraw.

Assessment:

95. If the Objective Structured Final Assessment (OSFA) for the Scientist Training Programme is postponed, as previously during the COVID-19 epidemic, interventions for completion of the programme will be employed again. The Independent Assessment of Clinical Competence (IACC) is the exit assessment for trainees on the Scientist Training Programme (STP).

    - The measures put in place will be based on those developed and successfully implemented earlier in the year to enable the completion of the new high stakes assessment for over 300 STP trainees in 2020. We will continue to ensure that the NHS has enough HCPC registered scientists going forward.
    - The OSFA is to be replaced with an independent trainee self-assessment against the components of practice for healthcare professionals. Trainees will also be required to have passed their MSc in Clinical Science and to have completed a proportion of their work-based training portfolio.
    - The Academy of Healthcare Science will provide an external review of a sample of trainee reflections and portfolios.
    - Trainees will also undertake a structured interview assessment after being allocated to an employer.

96. The data demonstrate that the IACC has met the aim of a synoptic exit assessment and achieved more in sending well trained, well prepared, safe and competent newly qualified Clinical Scientists out into the NHS and adjunct private services, carrying with them a further practised valuable and useful skill of reflection

Placements:

97. NSHCS will continue to monitor any disruption to placements, working where it is appropriate to do so with local providers. HEE guidance will continue to underpin all planning and response.

Deployment/Re-Deployment:

98. The numbers of learners that volunteered and were accepted for deployment was small but critical, as they included the biomedical and clinical scientists in laboratories who helped with the testing and the clinical engineers and respiratory physiologists who helped in critical care. HEE guidance will continue to underpin NSHCS planning and response.

Advice and Support for Learners:

99. Advice and support for learners will continue to be published via the NSHCS microsite:
    - https://nshcs.hee.nhs.uk/programmes/stp/trainees/
    - https://nshcs.hee.nhs.uk/coronavirus-COVID-19-19-information/ptp-student-information/
    - https://nshcs.hee.nhs.uk/programmes/hsst/trainees/

Physicians Associates

100. On 24 March 2020 the Faculty for Physician Associates (FPA) and Physician Associate Schools Council (PASC) recommended that courses training Physician Associates in the UK accept no fewer than 1400 hours clinical practice and that there would be some flexibility in clinical areas in which this could be achieved. A further recommendation, in view of the continuing impact of COVID-19, was agreed in June 2020 with 'an interim measure' for Year 2 students to allow 10% of these hours to be provided by alternative methods such as simulation, while maintaining a minimum of 1260 clinical practice hours.

101. This was to be reviewed in Autumn 2020 to see *'if the adjustment needs to be applied to Year 1 students'*. Many of these Year 1 students have now entered their 2nd year of study and there is considerable concern from Programme Leads of the continuing impact on the provision of clinical placements through the next 12 months.

102. Following this review it has been agreed, by PASC and FPA, that the measures agreed in June 2020 for PA students should continue for the next 12 months. GMC regulation is currently still on track for Autumn 2021, by which time requirements for programme outcomes will have been reviewed as will the pre-requisites for eligibility to take the PA National Examination.

103. Further updates can be accessed on the FPA website: https://fparcp.co.uk/about-fpa/news/COVID-19-19/

10. LEARNER REDEPLOYMENT AND SCHEDULED PLACEMENTS IN COVID-19 FACING SERVICES

1. This framework provides guidance for the safe and effective deployment of multi-professional healthcare students and postgraduate trainees to support the management of a resurge of the novel coronavirus, COVID-19, in England. Alignment of nursing and midwifery learners is covered in separate guidance.

2. A summary table, mapping professional skills and competencies to the COVID-19 response is provided in Table 1.

Circumstances of the resurge

3. While the NHS can now benefit from the established protocols and lessons learned from the initial COVID-19 surge, the circumstances of this resurge differ significantly from the first.

4. In March 2020, students and trainees were nearing the end of the education and training cycle. Many had attained the skills and experience required to safely join the workforce as temporary registrants or as healthcare assistants. In the case of final year medical students who had passed their finals, these individuals could graduate early to enter the clinical workforce as provisional registrants.

5. For the resurge, as students are commencing the academic year, early provisional or temporary registration will not be a feasible option for boosting workforce capacity. Furthermore, HEE has committed not to redeploy students from their scheduled placements. This is to avoid any further disruption to education, which could risk students being unable to complete the clinical and tuition hours required to achieve professional registration.

6. However, where proper measures have been taken – including a robust placement risk assessment – students may be able to support service delivery and continuity during a COVID-19 resurge.

7. Postgraduate medical and dental trainees, and healthcare science staff in training to become clinical scientists, biomedical scientists and healthcare science practitioners may be redeployed by their employer to support COVID-19 facing services. Any redeployment must be agreed in advance with the Postgraduate Dean or the National School of Healthcare Science. Redeployed learners will be closely monitored supported by HEE to continue with competency acquisition and progression.

8. To note, there has been a reported increase in demand for influenza (flu) vaccinations compared to previous years, and the Government is also consulting on changes to the Human Medicines Regulations 2012 to support vaccine rollout. Improved access and uptake of the flu vaccine may reduce the risk and impact of Winter pressures on acute and critical care services in England during a potential COVID-19 resurge.

Key enablers for learner placements

9. As with the initial wave, HEE should work with system partners, to ensure the following measures are in place to support learners in COVID-19 facing services:

    1) Appropriate supervision and learner support in line with regulatory requirements.

    2) Access to appropriate Personal Protective Equipment (PPE) for the task at hand, provided by the placement providers as per substantive staff.

    3) Assurances from the professional regulators that fitness to practice processes for redeployed students and trainees will be proportionate to the extraordinary circumstances of the global pandemic.

    4) Robust indemnity cover, that provides protection to students, trainees and members of the registered clinical workforce, who are redeployed to new clinical service areas to support the COVID-19 response.

5) Suitable arrangements to ensure that all students who are deployed to support the COVID-19 response are eligible for life assurance payments.

6) Access to the NHS comprehensive package of mental health and wellbeing resources and support

10. Universities and professional regulators will need to consider how pre-registration students can be supported to meet their course requirements if there is significant disruption to their planned clinical placements due to COVID-19.

11. Individuals who have been assessed as having an increased risk of severe illness due to COVID-19, or live with someone who is high risk, may request alternative placement based on health grounds. For undergraduate and pre-registration learners, decisions should be made by the HEI and placement provider in discussion with the student and be properly risk assessed

12. Further guidance on these enablers and expectations is outlined in HEE's Operational Guidance for managing the training workforce during a resurge.

13. Students need access to appropriate IT and governance to support technically enhanced clinical services

Key documents

14. This framework draws upon the following documents and guidance, which were prepared in response to the first COVID-19 surge:

- NHS England & NHS Improvement (NHSE&I) Clinical guide to adult critical care during the coronavirus pandemic: staffing framework, first published 25th March 2020, and referenced in the clinical guide for surge management, published 16th May 2020
- NHSE&I: COVID-19, Deploying our people safely, published 30th April 2020
- NHSE&I, Redeploying your secondary care medical workforce safely, version 2 published 14 July 2020
- Deploying the healthcare science workforce to support the NHS clinical delivery plan for COVID-19, last updated 12th May 2020

15. The relevant documents should be read and understood in full before considering whether to redeploy a student or trainee.

Undergraduate medical trainees

16. As medical students are commencing the academic year, and final exams have not been undertaken, it will not be possible for students to graduate early and enter the clinical workforce as provisional registrants. Furthermore, HEE has committed not to redeploy students from their scheduled clinical settings.

17. Where students have scheduled placements in intensive care settings, the Adult Critical Care (ACC) staffing framework recommends that medical students can fill bedside support workers roles in ACC settings. Medical students can also perform a range of duties and procedures including taking blood, talking to relatives of patients in critical care and supporting A&E receptions.

Postgraduate medical trainees

18. HEE's workforce planning & intelligence directorate has produced a model for identifying and prioritising postgraduate trainees with the relevant competencies to be deployed to ACC and intensive care (IC).

19. To note, the analyses only represent the pool of doctors who **could** be deployed, many of whom will be required to service non-COVID care in their particular specialty. Separate conversations are therefore required to assess and balance supply and demand across COVID and non-COVID settings. The NHSE&I guidance on redeploying the secondary care medical workforce safety provides an essential reference for informing decisions to redeploy across settings.

20. The model groups the medical workforce into five categories, based on the following:

    Groups 1 & 2: Specialist airway doctors, relevant to beds requiring Ventilation (V), non-invasive ventilation (O+) demand

    Groups 3-5: Relevant to beds requiring general oxygen treatment (O). HEE advises only reporting the sum of **groups 3 and 4** as group 5 have less competency for the COVID-19 airways specific activities.

    The relevant specialties are as follows:

Grp.	Specialties	
1	Anaesthetics Intensive care medicine Paediatric intensive care medicine	Pre Hospital Emergency Medicine Respiratory medicine Paediatric respiratory medicine
2	Accident & Emergency Medicine Cardiothoracic surgery Emergency medicine	Paediatric Emergency Medicine Otolaryngology
3	Acute internal medicine General Internal Medicine Cardiology Endocrinology Gastroenterology Genito-urinary medicine Geriatric medicine Haematology Infectious Diseases	Medical Microbiology and Virology Neurology Paediatric cardiology Renal medicine Rheumatology Stroke Medicine
4	General Surgery Neurosurgery Vascular Surgery Oral and maxillo-facial surgery	Community Sexual and Reproductive Health Nuclear medicine Palliative medicine

21. Trainee suitability for deployment to IC and ACC is prioritised as follows:
    a. **First:** those training towards CCT in any of the specialties identified **within the group.**
    b. **Second:** the level of those so training.
    c. **Third:** whether and, if so, how recently the trainee had a placement in Anaesthetics or ICM.

22. Thus, it is assumed further that:
    a. Doctors training at a higher level towards specialism in any of the specialties in Groups 1 and 2, who have a current placement in anaesthetics or ICM are likely to exhibit greater airways competence than other trainees.
    b. Doctors training at a lower level towards specialism in any of the specialties in Groups 1 and 2 who have a current placement in anaesthetics or ICM are likely to exhibit greater airways competence than any other trainees other than the above and so on.

23. Medical Support Workers and desk co-ordinators will be drawn from any doctors not deployed elsewhere (and returning doctors, not factored in yet), including Foundation doctors who are not included in the groups above.

24. During the first peak, some local units redeployed their ST1 and ST2 trainees and non-training grades to support priority services. The NHS has committed to maintain core services during a COVID-19 resurge – particularly cancer and diagnostic services. Therefore, services should take careful consideration before redeploying radiology trainees.

25. HEE has produced an instructional video on the COVID-19 postgraduate medical ACC redeployment tool, which has been operationalised into a dashboard for identifying suitable trainees directly from live TIS datasets.

26. During the first peak, some local units redeployed their ST1 and ST2 trainees and non-training grades to support priority services. The NHS has committed to maintain core services during a COVID-19 resurge – particularly cancer and diagnostic services. Therefore, services should take careful consideration before redeploying radiology trainees,

Dentistry and Dental Care Professions

27. Dental Foundation Trainees (DFTs) and General Dental Practitioners could support the COVID-19 response by provide advice via NHS111 or act as health care assistants (HCAs) in mental health or non-COVID wards. Redeployment of DFTs would require approval from the Postgraduate Dental Dean and the employer of the trainee.

28. HEE can also work with employers to identify suitable roles for Dental Core and Specialty Trainees to support the pandemic surge.

Nursing and Midwifery Students

29. The following questions will be addressed when HEE considers escalation to the NMC, HCPC and Approved Education Institution (AEI) to consider students supporting the release of other nursing staff to critical care:

    1) Scale: Numbers in year groups and importantly if age/ethnicity demographic data on students is available to assess risk: There are >100,000 medical/dental/nursing/midwifery students. There is also variation in the structure of course programmes regarding timing of clinical placements.

    2) Phasing of placements: the majority of students undertake clinical practice, many during the first two semesters (i.e. September-December, January-March), although first year midwifery students typically do not begin clinical practice until January.

    3) Risks: At university and on placement (i.e. onward progression, morbidity and mortality etc, care homes, social care placements). The majority of clinical placements are in NHS settings, some in social care, some in private providers. Logistics, volume and speed of testing both before - and importantly repeatedly throughout - placements will be challenging, particularly where programmes differ.

    4) Options ranging from testing approaches to pausing all placements. COVID-19 cases within university campuses should be broadly manageable, whereas off-campus containment e.g. in social care and care settings will be more challenging. The 'bubble' concept in healthcare students is not feasible, as most live and socialise in mixed population settings with non-healthcare peers.

    5) Scope for alternative experience e.g. through simulation in line with the appropriate regulator guidance

Allied health profession (AHP) students

30. As with all students, AHP students should be retained on scheduled placement wherever possible and appropriate, where they may contribute to service, or in University. Universities should aim to retain a blended learning approach to learning that provides access to practical learning alongside opportunities for simulated/technically enhanced clinical service placements.

31. There remains a significant shortfall in placement time which must be accommodated, alongside restart and growth. Across the 14 professions there is significant variation and risk.

32. Where AHP students are safely deployed to areas of COVID-19 facing clinical care, and where suitable supervision is in place, they may be able to support the following activities:

Paramedics:	Airway management, basic life support, supporting ambulance service capacity, support care in community.
Physiotherapists:	Intensive care respiratory care. Supporting cross-sector rehabilitation services to drive hospital flow, minimise admission of frail and elderly and optimise early discharge and recovery at home
Occupational Therapists:	Intensive care rehabilitation. Supporting cross-sector rehabilitation services to drive hospital flow, minimise admission of frail and elderly and optimise early discharge and recovery at home
Operating Department Practitioners:	Airway management, basic life support, supporting critical care capacity
Dietetics:	Intensive care nutrition. Nutritional support to drive hospital flow and optimise early discharge and recovery at home
Speech and Language Therapy:	Intensive care ventilatory weaning, speech and swallowing. Supporting cross-sector rehabilitation services and optimise early discharge and recovery at home

Healthcare scientists

33. NHS England & Improvement has published staffing scope and competencies across the four branches of healthcare science: laboratory (life) sciences, physical sciences, physiological sciences, and clinical bioinformatics. Each branch is grouped into:

Category A: Qualified clinical scientists, biomedical scientists, and healthcare science practitioners
Category B: Healthcare science staff in training to become clinical scientists, biomedical scientists and healthcare science practitioners
Category C: Healthcare science support staff
Category D: Clinical academics with healthcare science or life sciences Experience

34. During the first peak, the numbers of learners that volunteered and were accepted for deployment was small but critical, as they included the biomedical and clinical scientists in laboratories who helped with the testing and the clinical engineers and respiratory physiologists who helped in critical care. HEE guidance will continue to underpin NSHCS planning and response.

35. A full competency map, outlining how each of these healthcare science staff groups can be found in Table 2.

Advanced Clinical Practitioner (ACP) redeployment

36. ACPs have a wide variety of clinical competencies and a varied background, often with extensive experience within their specialty and sometimes other specialties. ACP redeployment should reflect the individual's experience and competency and should be decided on an individual basis through consultation with the individual ACP. Some ACPs will feel comfortable being deployed outside their usual specialty, however others will not. Equally, some could be deployed at the same level of supervision as they have within their usual specialty, whereas others may need additional supervision.

TABLE 1: UNDERGRADUATE STUDENTS SHOULD NOT BE REDEPLOYED FROM THEIR SCHEDULED PLACEMENTS. THIS GUIDANCE OUTLINES ACTIVITIES THAT STUDENTS COULD SAFELY UNDERTAKE TO SUPPORT SERVICE CONTINUITY WITHIN THEIR PLANNED PLACEMENT

Learner Group	Relevant guidance	ICU / Critical Care	Nightingale Hospitals	Ambulance Services	Rehab-ilitation	Testing	NHS111	Supporting Non-COVID-19 services
Undergraduate medical students	Adult Critical Care staffing framework	Bedside support workers, runner for mobile emergency rapid intubation team, assistant for line team, supporting comfort/ hygiene team or equipment and preparation team						Continuation in planned clinical placements where possible.
Postgraduate medical trainees	Adult Critical Care staffing framework	Prioritisation: 1st those training towards CCT in any of the specialties identified within the group; 2nd level of training; 3rd how recently has the trainee had a placement in anaesthetics or ICM? Group 1 (V and O+): Anaesthetics, Intensive care medicine, Paediatric intensive care medicine, Pre Hospital Emergency Medicine, Respiratory medicine, Paediatric respiratory medicine Group 2 (V and O+): Accident & Emergency Medicine, Cardiothoracic surgery, Emergency medicine Group 3 (O): Acute internal medicine, General Internal Medicine, Cardiology, Endocrinology, Gastroenterology, Genito-urinary medicine, Geriatric medicine, Haematology, Infectious Diseases, Medical Microbiology and Virology, Neurology, Paediatric cardiology. Renal medicine, Rheumatology, Stroke Medicine Group 4 (O): General Surgery, Neurosurgery, Vascular Surgery, Oral and maxillo-facial surgery, Community Sexual and Reproductive Health, Nuclear medicine, Palliative medicine Trainees not within groups 1-4 may be deployed as medical support workers and desk co-ordinators (includes foundation trainees)	Group 1-4 specialties, prioritised as follows: 1st those training towards CCT in any of the specialties identified within the group; 2nd level of training; 3rd how recently has the trainee had a placement in anaesthetics or ICM? Trainees not within groups 1-4 may be deployed as medical support workers and desk co-ordinators (includes foundation trainees)				Shielding trainees	

Learner Group	Relevant guidance	ICU / Critical Care	Nightingale Hospitals	Ambulance Services	Rehab-ilitation	Testing	NHS111	Supporting Non-COVID-19 services
Postgraduate Dental Trainees	Adult Critical Care staffing framework	DCT & DST: Bedside support workers					DFT: providing NHS111 advice	DFT working as HCA in non-COVID-19 or Mental Health settings
Healthcare scientists	Deploying the healthcare science workforce to support the NHS clinical delivery plan for COVID-19	Physiological sciences Category B: (with additional training) support Critical Care teams providing direct and indirect critical care support Physical Sciences Category B: (with additional training and supervision) ensure logistics, maintenance, assessment and effectiveness of essential equipment / devices to support Critical Care Clinical bioinformatics: Category B: support the management of diagnostic monitoring functions, data and information	Physiological sciences Category B: (with additional training) support Critical Care teams providing direct and indirect critical care support Physical Sciences Category B: (with additional training and supervision) ensure logistics, maintenance, assessment and effectiveness of essential equipment / devices to support Critical Care Clinical bioinformatics: support the management of diagnostic monitoring functions, data and information			Life sciences Category B: (with additional training) undertake, support and disseminate COVID-19 testing for staff and patients OR assist with this Physical Sciences Category B: (with additional training and supervision) ensure logistics, maintenance, assessment and effectiveness of essential equipment / devices to support labs		Clinical bioinformatics: support the management of diagnostic monitoring functions, data and information

Learner Group	Relevant guidance	ICU / Critical Care	Nightingale Hospitals	Ambulance Services	Rehab-ilitation	Testing	NHS111	Supporting Non-COVID-19 services
AHP students	NHSE&I: COVID-19 Deploying our people safely	Operating Department Practitioners: Airway management, basic life support, supporting critical care capacity Dietetics: intensive care nutrition Speech & Language Therapy: Intensive care ventilatory weaning, speech and swallowing.		Paramedics	Physio-therapists Speech & Language Therapists			All AHP students: B3 HCA

TABLE 2: Healthcare science professionals staffing scope and competencies framework

Healthcare Science Professionals

Life Sciences	Physiological Sciences	Physical Sciences	Clinical Bioinformatics
Primary Role: to undertake, support and disseminate Covid19 testing for staff and patients	**Primary role:** to support Critical Care teams providing direct and indirect critical care support	**Primary role:** to ensure logistics, maintenance, assessment & effectiveness of essential equipment/devices to support Critical Care & labs	**Primary role:** managing diagnostic monitoring functions, data and information
COMPETENCIES **Category A** On call trained and able to: Perform COVID19 Testing **Categories B-D** On call trained and able to perform testing with additional training B/D or to assist with it B:	**COMPETENCIES** **Category A** part of Critical Care teams involving direct patient care **Categories B/D** able to support with additional training/ supervision direct patient care **Category C** able to support the Critical Care team/environment but with minimal direct patient involvement	**COMPETENCIES** **Category A** Medical Device Risk Management & Governance: Optimisation of Medical Device Effectiveness & Efficiency, Equipment Acquisition/adaptation, modification /assessment, & installation Imaging: urgent diagnostic testing **Category B/D** able to support with additional training/supervision the above activities **Category C** provide support for this work but under strict protocols and supervision	**COMPETENCIES** **Categories A/D** Physical Sciences Managing diagnostic, monitoring functions, specification, procurement, design, software, patient data **Categories B/C** to support these functions

11. MEDICAL WORKFORCE PLANNING AND DEPLOYMENT TO SUPPORT SURGE SERVICE DELIVERY

HEE support to NHS England & Improvement

Introduction

- There are lessons to be drawn from the contribution the HEE regional teams made to the whole system medical workforce planning and deployment decisions taken to meet safely the surge in service demand from the COVID-19 pandemic. This section draws on these lessons, presenting a process for HEE's national and regional teams to facilitate medical workforce planning and deployment in support of service delivery in England.

Supporting surge service delivery

- HEE will support NHS England and NHS Improvement on workforce planning by providing:

- supply modelling through national and regional business intelligence teams, to complement the clinically led and identified workforce demand
- data for workforce including consultant, training and staff and associate specialist grades
- data analytics, using tools such as the three-way analysis which triangulates hierarchy of the doctors' capability, categories of need, and the speed of deployment (as detailed in the resource section below)
- input from this to inform rapid skills development needs, alongside workforce analysis and associated training/development/upskilling plans.

- HEE will act to boost the numbers of doctors, with a focus on those not currently in clinical practice, by:

- enabling a system to prioritise and where appropriate, ask staff out of training programmes if they can return to the frontline; mindful that any moves should maintain the workforce supply, maintain training quality and avoid further delay to progression of doctors and entry into the qualified workforce.
- working with Medical Schools to enable students to support provision through working in healthcare assistant level roles, where this will not affect their studies.

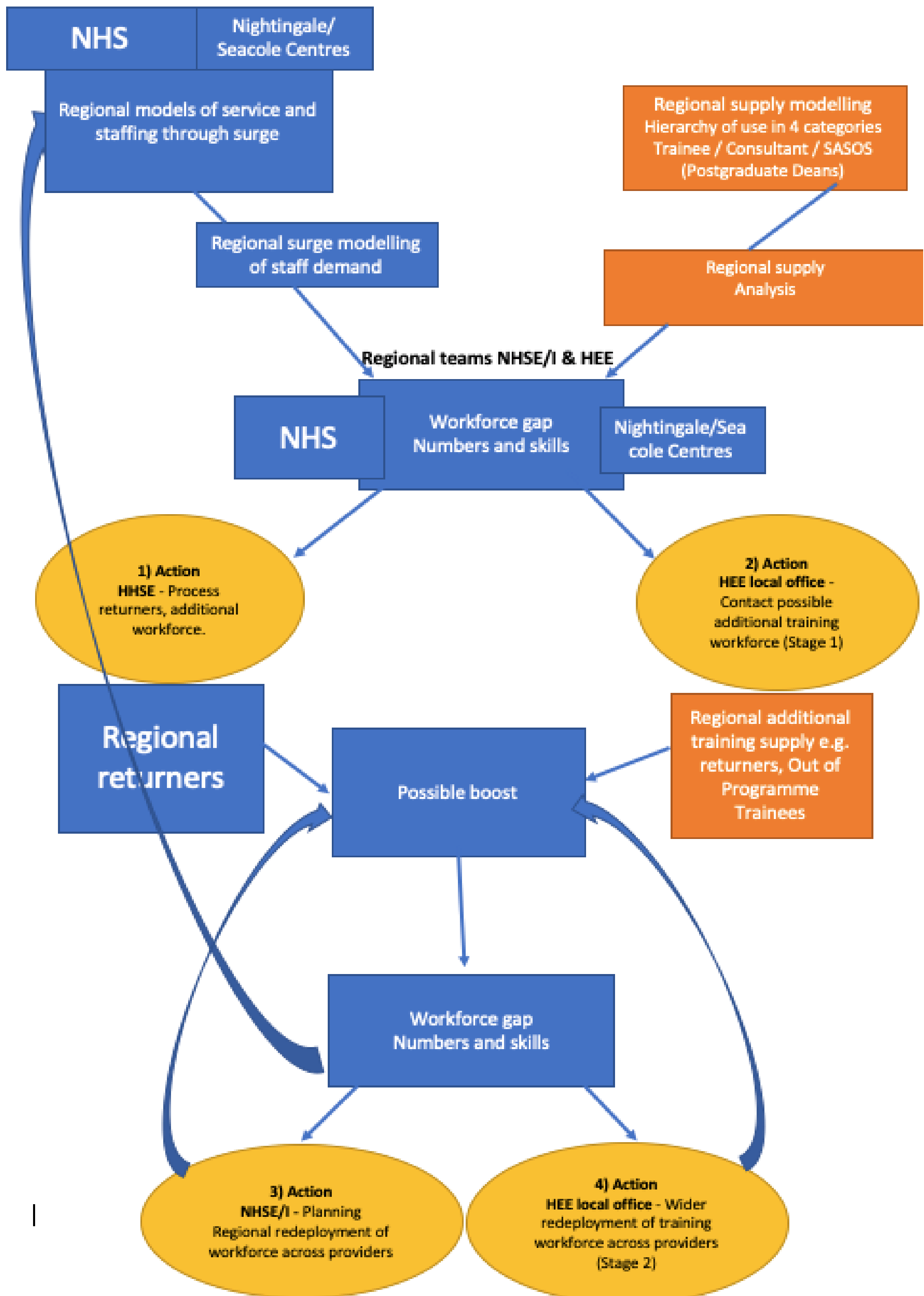
- HEE will then facilitate effective deployment by:

- working with NHS England and NHS Improvement to consider all available data and to provide additional data to regional workforce hubs on numbers of these doctors willing to return to clinical practice, and their recommended deployment
- developing redeployment strategies for learners that take into account areas of greatest service need (as defined by regional and local system Gold Command and/or trust workforce leads) whilst maintaining an equal focus on delivering critical non COVID care or elective work, maintaining education and training progression and trainee and patient safety (refer to the HEE statement on educational quality)

- developing contingency plans with local system engagement for possible redeployment of doctors across providers to provide short term support for local surges with doctors who have experience in these settings

- Regional Postgraduate Deans will ensure that decisions about moving trainees take into account regional and local surges impacting on clinical demand, staff sickness and total workforce availability. The doctor learning needs of doctors in training (including safe induction and supervision) and progression must also be part of this decision making undertaking accurate data collection to inform future training needs analysis and trainee progression.

- The ‘Workforce Planning Process’ diagram below illustrates how these processes worked together to allow regional teams to chart their progress in preparing for medical workforce deployment in response to a surge in service demand.


WORKFORCE PLANNING PROCESS
NHS
Nightingale/ Seacole Centres
Regional models of service and staffing through surge
Regional supply modelling
Hierarchy of use in 4 categories
Trainee / Consultant / SASOS
(Postgraduate Deans)
Regional surge modelling of staff demand
Regional supply Analysis
Regional teams NHSE/I & HEE
NHS
Workforce gap Numbers and skills
Nightingale/Seacole Centres
1) Action
HHSE - Process returners, additional workforce.
2) Action
HEE local office - Contact possible additional training workforce (Stage 1)
Regional returners
Possible boost
Regional additional training supply e.g. returners, Out of Programme Trainees
Workforce gap Numbers and skills
3) Action
NHSE/I - Planning
Regional redeployment of workforce across providers
4) Action
HEE local office - Wider redeployment of training workforce across providers (Stage 2)

Tools and resources

Three-way analysis for deployment of medical workforce
The analysis for deploying the medical workforce will depend on the triangulation of three factors; 1. Capability and seniority, 2. categories of staffing need and 3. speed of deployment.

Factor 1: Capability and seniority hierarchy
This may vary with regional priorities for staff expansion. Specialties familiar with working in intensive care settings and readily able to be deployed. This comprises those currently training or in current practise in the following specialties:

- Intensive Care Medicine
- Anaesthesia
- Respiratory Medicine
- Paediatric Intensive Care Medicine
- Cardiothoracic Surgery
- Pre-Hospital Emergency Medicine

There is also a group of doctors who have familiarity with, but not current ICU work, namely:

- Emergency Medicine
- Paediatric Emergency Medicine
- Acute internal Medicine
- And potentially Otolaryngology

Doctors in core training programmes or locally employed doctors who encompass intensive care or anaesthetic settings:

Acute Common Core Stem – Anaesthesia
Acute Common Core Stem – Medicine
Acute Common Core Stem – Emergency Medicine

The next group have acute skills across a broad range of medicine, including that of resuscitation, stabilisation and the management of emergencies:

- Core Medicine Trainees
- Core Surgical Trainees
- All ST3 Physician and Surgical Trainees
- Interventional Radiologists
- Foundation Year 2 doctors

Level of seniority (within or outside or training) of the professionals

- CCT or CESR holders (Consultant level)
- Higher Specialty Trainees, including higher run-through trainees (Senior clinical fellows, clinical lecturers, associate specialist or equivalent) and Consultants from other specialties
- Core Trainees, including lower run through trainees (clinical fellows, trust fellows, staff grade, ‘F3’ doctors)
- Foundation trainees (FY2>FY1)

To maintain critical care in non COVID areas, for those currently training or in current practise deployment will need to be balanced with the need for trainees to remain in placements to enable continued critical care delivery.

Factor 2: Categories of staffing need
Broadly, there are four areas of staffing that need to be considered:

1. Staff who service the COVID-19 caseload.
2. Staff who provide other critical functions such as cancer and other non-elective care
3. Staff enabling flow (discharges and avoiding admissions e.g. community staff, GP, 111)
4. Other staff, e.g. covering elective admissions - who could be redeployed to one of the above should that become essential.

Factor 3: Speed of deployment
The speed at which professionals can be redeployed and returning/entering the workforce will depend on their time out of current practice and their associated refresher training need requirements:

- Currently in ICU or anaesthesia attachments or have had recent experience (<1year, 1-2 years, depending on amount), including COVID-19 relevant experience
- More distant experience (1-2 years, 2-3 years; > 3 years) but currently in training/NHS roles
- Returners (1-2 years, 2-3 years; > 3- 5 years)
- Returners (5+ years) where they can be appropriately deployed safely.

Deployment tiers from the three-way analysis
The above analysis can be conducted to determine what 'Tier of Redeployment', such as the one illustrated below, to determine the placement of staff returning, starting early or returning to training.

The table below details the tiers for rapid assessment of the potential workforce supply.
Tiers for rapid assessment of the potential workforce supply

Deployment Tiers for placement and contact priority for returners (medical practitioners)
Acute care +/- COVID-19 patients - capable of greater degree of independent practice with off-site support.
Non acute care non COVID-19 patients but freeing up workforce for Tier 1 redeployment - capable of a greater degree of independent practice with less close on-site supervision.
Office based work - capable of low-level clinical duties/supporting admin for which they need full supervision, or out of practice for significant time but could provide educational and trainee support activities.
Potential concerns re fitness to practice TBC – hold for further info/decline if confirmed.

Example of this in practice

To illustrate the above three-way analysis and tiering for deployment
Green = first priority for deployment
White = next priority for deployment
Amber = deployed into supporting role where this is required
Red = hold/decline

Screeners comments	Tier & RAG rated for redeployment
Remote only > 3 years since last clinical work but has non acute medical experience could be 111 or back office support medical services	3. Office based work
75 years old > 3 years since clinical practice, has extensive PH experience could support back office/co-ordination/leadership function perhaps	3. Office based work
Sports medicine – currently in practice	2. Non acute care no COVID-19 patients
Cardiology > 3 years since last in clinical practice at XXX Trust	3. Office-based work
Former trainee known to us, delays due to illness and performance, managed out of programme. Would require intensive supervision. Not to be deployed at current stage, potentially decline.	4. Potential concerns re fitness to practice TBC – hold for further info/decline if confirmed
Current anaesthetic/ICM can ventilate	1. Acute care +/- COVID-19 patients
Current medicine experience < 3 years since clinical practice	1. Acute care +/- COVID-19 patients / 2. Non acute care no COVID-19 patients

The above analysis and tiering are best done by an educator who does not or cannot work on the front line, ideally with knowledge of local trusts. Ongoing input and review from clinicians and service managers within trusts into the Regional Workforce Cells also enables the emerging situation to be factored in, particularly for perspectives of likely roles and staffing needs for matching. Annex 1 illustrates the processes involved in delivering from the learning in London.

Other areas for consideration

Processes for speeding up the analysis of data

- Dedicated SharePoint folders with live data and redeployment spreadsheets that NHS England and NHS Improvement, HEE and Leadership Academy can access, will enable lists to be worked on by multiple users and updated/saved (for example, NW Leadership academy do all HR and employment checks in parallel with the initial screening of the spreadsheets).
- Online form for trusts to submit their requirements (what staffing do they need and how many)
- Match requirement returns against the processed lists
- Once matched, the trust is informed and contacts made for induction, etc
- Recruitment teams may be well placed to do this as they have the expertise for mass matching, etc.

Redeployment decisions

Whilst the focus remains on building capacity in critical care within trusts to manage service surges of the COVID-19 outbreak, it is important that other essential health care services are maintained and critical staffing capacity is not depleted in mental health, primary care and social care.

Support and Wellbeing Access

It is crucial that any returning or redeployed staff, in whatever capacity, receive ***sufficient induction*** and ***supervision*** to ensure staff and patient safety. Deployed staff and those responsible for them should therefore be asking:

- Has a basic orientation to the workplace taken place (e.g. location of fire escapes, key clinical equipment, rest facilities, patient rooms)?
- Is there access the necessary systems (e.g. log-ins for IT access, for test results, scans etc.)?
- Have staff received mandatory training relevant to their role (e.g. Basic Life Support, Advanced Life Support, Advance Trauma Life Support, Safeguarding, Infection Control)
- Are staff being asked to undertake tasks beyond their level of competence/training or which they do not feel confident to undertake?
- Do staff have access to appropriate clinical colleagues who can provide clinical supervision/support and advice when they need it? (e.g. nurses, specialty doctors, peers)?
- Where additional facilities are commissioned, has a Director of Medical Education/Director of Clinical Education been appointed to support training for staff engaged in both COVID-19 related and other areas of practice?
- Do staff know who to notify (and how) within the ward area/ department/organization if they have concerns?

Each organisation will have policies that enable its staff to raise and escalate concerns. HEE has set out how it will support and enable escalation of concerns from trainees here.

12. ONLINE RESOURCES AND GUIDANCE

This section brings together the documents and guidance referenced throughout the Operational Guidance document, in addition to other useful online resources.

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For Regional COVID-19 Updates

In addition to HEE's national guidance and guidance from all four statutory education bodies you can access specific information from across the seven regions:

- East of England
- London
- Midlands
- North east and Yorkshire
- North west
- South east
- South west

Wellbeing

NHS staff have been given free access to a number of wellbeing apps from now until the end of December 2020 to support their mental health and wellbeing.

This includes access to SilverCloud (offers free wellbeing support), #StayAlive (a suicide prevention resource), Daylight (provides help to people experiencing symptoms of worry and anxiety), Sleepio (a sleep-improvement programme), Unmind (helps you measure and manage your personal mental health needs) and Headspace (helps reduce stress, build resilience, and aid better sleep).

The NHS has launched a mental wellbeing support package for its 1.4 million staff; to help them as they help people deal with the pressures faced during this global health pandemic.

Government Updates

The latest government's response to coronavirus and travel advice can be found on gov.uk.

For all Government published guidance about coronavirus (COVID-19) for health and social care settings, other non-clinical settings, and for the general public you can find information on the gov website.

Healthcare Student Resources

The Office for Students has compiled information for healthcare students, with useful links to the healthcare regulator, medical schools and DHSC guidance

Public Support and Guidance

- Health Education England, Library and Knowledge Services provides Information and resources about the Coronavirus

- Get the NHS COVID-19 app to help protect yourself and others

COVID-19 eLearning

HEE has made its Coronavirus eLearning resources freely available to colleagues working in the NHS, independent sector and social care. We have removed the requirement to register and log in.

We recognise that this is a global issue, so we have made the Coronavirus programme available to international users for free via our partner organisation, eIntegrity. If you are a learner outside of the UK please select here

Professional Bodies' COVID-19 Guidance

Medicine: British Medical Association

Dentistry: British Dental Association

Nursing: Royal College of Nursing

Midwifery: Royal College of Midwives

Allied Health Professions:

- British Association of Art Therapists
- British Association of UK Dieticians
- Royal College of Occupational Therapists
- College of Paramedics
- College of Podiatry
- British Association of Prosthetists and Orthotists
- British Association of Drama Therapists
- British Association for Music Therapy
- British and Irish Orthoptics Society
- Chartered Society of Physiotherapy
- Society of Radiographers
- Royal College of Speech and Language Therapy

Pharmacy and Pharmacy Technicians

Royal Pharmaceutical Society

Association of Pharmacy Technicians UK

Health Care Science

Links to the healthcare science professional bodies.

Medical Education

Students and trainees are encouraged stay up to date with information and guidance from across the system:

- Academy of Medical Royal Colleges COVID-19 guidance
- General Medical Council Coronavirus information and guidance
- COPMeD

- For specific information on cancellations and rescheduling of exams please visit your relevant Medical Royal College website.

Other NHS and ALB Resources

For COVID-19 guidance for NHS workforce leaders go to NHS Employers website.

NICE have brought together guidance, resources and other information to help support the health and social care system as it continues to respond to the pandemic.

For the latest Coronavirus content for NHS Services in England, visit the NHS England website

Workforce Deployment

- NHS England & NHS Improvement (NHSE&I) Clinical guide to adult critical care during the coronavirus pandemic: staffing framework, first published 25th March 2020 and referenced in the clinical guide for surge management, published 16th May 2020

- NHSE&I: COVID-19, Deploying our people safely, published 30th April 2020

- NHSE&I, Redeploying your secondary care medical workforce safely, version 2 published 14 July 2020

- Deploying the healthcare science workforce to support the NHS clinical delivery plan for COVID-19, last updated 12th May 2020

ANNEX A

List of other programmes leading to registration or qualification outside of the DHSC tariff regime

1. Advanced Clinical Practitioner
2. Cytology
3. Dental Nurses
4. Dental Technicians
5. HCS Higher Specialist (HSST)
6. HCS Practitioner Training Programme (PTP)
7. HCS Scientist Training Programme (STP)
8. Health Visiting
9. IAPT - High Intensity Practitioner
10. IAPT - Other Modalities
11. IAPT - Psychological Wellbeing Practitioner (Low intensity)
12. Pharmacy Technician
13. Physicians Associate
14. Sonographer post-registration
15. Ultrasound/Sonographers