The Strategy Unit.

Herefordshire and Worcestershire COVID-19 Response

System Findings

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Acknowledgements: Thank you to the CCG who recognised the value of and need for this qualitative evaluation at a very early stage of the pandemic and approached the Strategy Unit to undertake it. We are very grateful for the opportunity to co-design and co-deliver this evaluation with colleagues from the CCG, Healthwatch and Age UK. The evaluation benefited from this wider knowledge and expertise of colleagues as well as their full engagement throughout, including (but not limited to): interview skills training; interviewing; detailed notetaking; participation in reflection meetings; and project management support. Thanks also to Worcestershire Acute Hospital Trust colleagues for giving us the opportunity to test our urgent care findings with them.

Our very special thanks to all those who participated in the interviews, especially members of the public and the professionals working at the front-line who provided such frank descriptions of their experiences of the first wave of the COVID-19 pandemic. We remain humbled by your accounts.

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1. Executive Summary

The Strategy Unit was commissioned by Herefordshire and Worcestershire STP to undertake a qualitative evaluation of their system response to COVID-19 as the pandemic unfolded. A total of 75 interviews were conducted between April -September 2020 with patients (n=7) and professionals (n=68) drawn from primary, secondary, community, residential and social care as well as commissioning organisations. Service level interviews focused on cancer and mental health as they were identified as facing specific challenges during the course of the evaluation.

In this report we provide an account of the local health and care system's response to a sustained period of crisis, which forced rapid transformation of services, from the perspective of those who led, delivered and experienced the changes. Learning is identified for the system – both for any future waves of the pandemic, and for the new business as usual that is emerging.

The demand for health and care services in Herefordshire and Worcestershire in the early phases of the pandemic was lower than expected for COVID-19 related care. The overall demand for usual care also fell; this was attributed and confirmed to be a combination of public anxiety about infection and individual reticence to be a burden on the NHS. Within this overall fall, there were extraordinary pressures placed on some aspects of the system, most notably care homes and community services. Services that were under less pressure took the opportunity to rethink and reconfigure their services with safety in mind.

The system's workforce rose to the challenge; individuals, teams and organisations did what was asked of them and also innovated to provide what they thought was right. A strengthened cross-organisational clinical voice has emerged from the crisis, with confidence in assuming collective ownership of future services. They will however require improved support, from both the centre and their local system, to sustain energy for change, especially in dealing with the health and care backlog and acuity of need. Patient accounts bear witness to the additional needs that resulted from social isolation.

The work of all health and care professionals, front-line or otherwise was emotional labour; the decisions they made were to safeguard those under their care above all else, including their own safety. For example, social workers did not wear masks if service users reacted badly to them and care homes stopped admissions if infection control measures could not be followed.

The impact of working through the crisis cannot be underestimated; the health and care system's workforce, as the UK collectively braces for a second wave, is exhausted and anxious for themselves, their families and their patients. Mental health practitioners understood that the health and wellbeing needs of staff were likely to be higher than patients.

Summary findings by patient and health and care sector are provided below.

Patients and Public

- Patients and the public worried about being a burden on the system when healthcare capacity was limited and refrained from accessing health services. Patients with specialist needs continued to have their specific health needs met; often this was through alternative means, e.g. remote consultations or home treatment rather than hospital visits.
- A range of individual preferences were shared for the use of remote consultations. In the main, most saw the benefit of continuing some types of appointments, e.g. non-acute triage and follow-up, as remote consultations after the pandemic.
- National communication for shielding and individual restrictions were confusing and hard to interpret. Local health services communication varied by service. The majority of patients and the public relied on their own ability to access the information they needed or consulted their own networks.
- Social isolation for individuals already suffering from poor health was another source of trauma. These emotional wellbeing needs were not always addressed, and the public perceived the access to Mental Health support to particularly difficult.

Primary Care

- Primary care leads quickly, proactively and collaboratively reorganised into Hubs to deliver services based on urgency of need and COVID-19 status. Individual practices followed, willingly and rapidly adapting to the changed way of working, with strong team spirit.
- This collaborative team working was made possible by the developing Primary Care Networks (PCNs) infrastructure; PCNs allowed primary care to bed in joined-up ways of working and as a result be more responsive and resilient.
- Support from national agencies was a source of disappointment and even anger for the GPs we spoke to. They felt let down on all aspects, including safety and guidance. Practices had to resort to personal networks to resource PPE, shielding lists were not fit for purpose and national guidance was late and/or confusing.
- The CCG support had been received positively: regarded as being most useful in providing IT hardware, training in software use, being an additional pair of admin hands, and for trusting GPs to lead.
- A collective sense of pride in the singular primary care voice has emerged from the crisis; primary care leaders were emboldened and empowered, ready to assume responsibility of future primary care services in their system

Acute Trust/Urgent Care

- Attendance for A&E fell in the initial phase of the pandemic but activity, which was both linked to COVID-19 and otherwise, rapidly returned. There was, however, ongoing concern that some emergency conditions such as chest pain were presenting late.
- Urgent Care teams, accustomed to a fast-pace of working, rapidly reorganised services to improve patient flow in A&E with organisational support. Changes were well received by staff and there was a desire to embed and sustain new ways of working and improved service delivery
- A high level of staff anxiety about the suitability of PPE provided was reported at the beginning of the pandemic. Professional opinion remained divided as to the appropriateness of the national guidance with regards to safety.

Community Nursing

- Community nursing leads had to plan innovatively, prioritise services and reorganise care. Staff were redeployed to support services most in need.
- Changes to community services were made quickly and in the absence of organisational and system barriers.
- The use of technology to deliver community services divided opinion. However, nursing leads saw the benefit of digital communication in their ways of working.
- Joint-working across organisational boundaries improved during the pandemic, however community nurses experiences of working with GPs varied.

Social Care

- Social Care had to rapidly change service models to respond to the increased demands of COVID-19.
- External care services cancelled home visits. Most social workers, however, continued with face-to-face services in patient homes.
- Social workers took on additional responsibilities, working extra hours (and sometimes often independent of wider team support), which impacted on their health and wellbeing.
- Wider use of technology to support and enhance staff communication was viewed positively.
- There was perceived to be an overload of general communication targeted at social care, but a lack of relevant guidelines – for example, for temporary adult social care funding.

Care Homes

- Care home managers galvanised their staff and enhanced team working to focus their efforts on their residents' health and wellbeing; in the absence of external visitors, care home staff tended to residents' emotional needs
- Care homes introduced strict infection control measures for staff including core team members that moved into the site over the peak of the first wave.

- Involvement of their staff in MDTs was welcomed by the homes; nursing managers especially felt the profiles of homes and the credibility of their work to be recognised within these meetings.
- Care homes needed specialist and remote clinical support from the system. There was limited resource available in commissioning organisations to provide this unexpected intensive support.
- The commissioning of future care home services by the system is expected to require greater alignment of resources and better oversight than currently exists.

Mental Health Services

- The emergence of new mental health needs and deterioration of existing illnesses is expected to create additional demand on mental health services.
- Delivery of technology-facilitated patient-centred care in mental health services demonstrated more variation by service, professional and patient than elsewhere.
- Collegiality and wellbeing support had allowed staff to deliver services at the time of the first wave; concerns were voiced for maintaining staff morale for future waves.
- Multi-disciplinary mental health team working at system level was desired for the future. National clinical guidance can be supportive of this.

Cancer Services

- Patients were reported to be positive about cancer services that they could access more rapidly, for example through virtual appointments especially when they were rurally based.
- Staff working in cancer services welcomed a more agile way of working, with services responding to need more flexibly, including in their use of technology to facilitate both patient care and ways of working.
- Cancer service leads were empowered and took responsibility for decision making for their service, unhindered by historical bureaucratic and siloed processes.
- There was widespread concern both about the poorer outcomes of later diagnoses and treatment for patients; and the emotional impact of this on the wellbeing of staff.

System

- The peak of pandemic demand was lower in Herefordshire and Worcestershire than predicted. However, care homes were placed under most pressure as activity was shifted from hospitals.
- There a system-wide culture change modelled by the system leaders. The clinical workforce especially was empowered to work collaboratively.
- System leaders were well supported by the command and control mechanism established for the pandemic response, as well as national and regional peers.

2. Introduction

COVID-19 has bought about profound changes to the health and care system. As rates of infection began to increase, there was anticipation of unparalleled demand on primary and secondary care. Health and care systems responded, in line with national guidance and local contexts, by implementing a range of innovations to achieve often transformational change.

At a very early stage of the pandemic, Herefordshire and Worcestershire STP recognised the need to understand and record these changes as they occurred; to capture learning for both immediate action and longer term (and second wave) planning. The Strategy Unit was commissioned to provide a qualitative evaluation to supplement the demand modelling and other analyses being undertaken, to capture the dynamic experience of health and care staff as they responded to the crisis.

Beginning with GPs[1] and then extending to other staff including mental health practitioners, cancer specialists, care home managers, system leaders and members of the public, the evaluation explored the experiences of 75 individuals. Whilst this is a large sample for a qualitative study, it was a purposive sample in that we sought to engage a wide range of perspectives rather than achieve exhaustive coverage across any one group. Throughout the discussion below, we have indicated whether the views reported were shared by a number of participants – providing a consensus – or were insights from more individual or minority perspectives.

The study followed a rapid-cycle evaluation model, with fortnightly reports of emerging messages (shared with the STP and then, following sign off, more widely via the Strategy Unit's networks including its website[2]) The Strategy Unit worked in partnership with staff from the CCG, providing training in qualitative research methods and facilitating reflective learning sessions that both informed the ongoing reporting and enabled the commissioning and service leads involved to take immediate actions based on first-person accounts.

This report provides an independent analysis of the evidence through the qualitative research across the system, mapped to the following key lines of enquiry:

- What has happened – what has worked well and less well?
- What is going to happen – what are the implications with respect to the backlog of patients, to ways of working?
- What needs to be in place to sustain effective change?

[1] Interim findings relating to primary care have previously been submitted and attached as Appendix C.
[2] https://www.strategyunitwm.nhs.uk/publications/primary-and-community-qualitative-insights

3. Method

The research was conducted by a blended team from The Strategy Unit and Herefordshire and Worcestershire CCG. The Strategy Unit provided training for CCG staff and supported them to conduct the research through regular participatory learning sessions that both reflected on the practical aspects of conducting the research and the findings that were emerging. Interviews with system leaders were conducted by researchers from the Unit.

3.1 Professional Interviews

Interviewees in a leadership position across different health and care sectors in Herefordshire and Worcestershire were identified by the CCG and invited to participate in the research. Service level interviews targeted cancer and mental health as these services were identified as facing specific challenges during the course of the evaluation. Semi-structured interviews were conducted by phone or video; the topic guide was co-designed by the Strategy Unit and the CCG (see Appendix A) and was structured to explore participants' perspectives of changes in service delivery in response to COVID-19; and, key lessons to inform recovery and future planning.

Interviews spanned a six-week period in April-June 2020. Table 1 presents a summary of the interviewees by sector.

Table 1: Details of interviews conducted with healthcare staff

Healthcare staff group	Time frame	Number
Primary Care	April-June 2020	14
Community Nursing	April-June 2020	11
Mental Health Services	May-June 2020	12
Cancer Services	June-September 2020	8
Care Homes	July- August 2020	5
Acute Hospitals (Urgent Care)	July-August 2020	5
Social Care	August 2020	5
System Leads	August 2020	5
Commissioners	August 2020	3
Total		**68**

Interviewees were asked for consent for recording and audio files were transcribed. Interviewers also took notes, which were shared with the Strategy Unit in the regular reflective workshops. Three rapid-cycle reports were produced from these notes and workshops[3]. This analysis informed a coding framework for qualitative analysis of the transcribed data, which was conducted using

[3] Rapid reports were previously shared in May (dated 02/05/2020, 10/05/2020 and 28/05/20).

specialist NVivo 12 software and is reported here (see Appendix A for more detail of the analytical process).

3.2 Patient Interviews

Seven in-depth narrative interviews were conducted with patients who had accessed at least one health care service in Herefordshire and Worcestershire during the pandemic (particularly under the lockdown restrictions). In recruiting patients for interview, particular attention was paid to involving those with protected characteristics, digitally excluded and using cancer services.

Recruitment was supported by patient advocacy organisations and clinicians, for example: HealthWatch Worcestershire promoted the study and invited participation through their postal bulletin, to reach the digitally hard to reach and those with protective characteristics (two participants). Age UK Herefordshire and Worcestershire also identified service users meeting these criteria from their Veterans Service (three participants); and the Cancer team at Worcester Acute Hospital identified two Cancer patients.

Narrative interviews were conducted by the Strategy Unit and CCG blended team, and Age UK. Each aspect of the interview process was informed by ethical guidelines and best practice in qualitative research. Interviews were designed to gain a rich and detailed account of individual patient experiences of the health and care services they had accessed in Herefordshire or Worcestershire during the first wave of the pandemic. Interviews were documented as narrative accounts using pseudonyms to preserve anonymity (see Appendix D).

Table 2 presents a summary of the participating patients.

3.3 Public Surveys

During the time of the first wave of the pandemic, public/patient surveys of the experiences of accessing and using health and care services in H&W were conducted in parallel, but separately, by HealthWatch and the CCG. These findings were shared with the project team and have been used to inform this evaluation.

- HealthWatch Worcestershire COVID-19 Survey – Spotlight Report August 2020, not yet published (HWW;1969 responses)
- HealthWatch Herefordshire COVID-19 Feedback Survey – Summary Report August 2020 (HWH; 258 responses)
- Herefordshire and Worcestershire CCG – Patient Experience Summary Report – September 2020 (H&WCCG; 76 responses)

Table 2: Profiles of patients interviewed, and health services accessed (pseudonyms used)

Name[4]	Description ***(Includes: age, gender, living arrangements, working status, health issues)***	Healthcare services accessed during the Pandemic
Alan	• 72 years old - Male • Living alone • Retired • Co-morbidities: Spinals stenosis, osteoarthritis, non-Hodgkin's lymphoma. type 2 diabetes, bipolar, lymphoedema and tissue viability issues.	• Podiatry • Cancer services • Mental health services • GP Surgery • District Nursing
Jane	• 79 years old – Female • Lives with husband • Retired • Has Ulcerative Colitis	• GP surgery • Pharmacy
Helen	• 52 years old – Female • Lives with husband 52 years old and two children • Works in teaching part time • Inoperable neuroendocrine cancer: tumours on pancreas and in liver.	• Cancer services
Jackie	• 52 years old – Female • Lives in a one bed flat with 22 year old son • Gave up work due to ill health • Terminal cancer of the liver and bowels • Previous heart surgery and is hard of hearing.	• Cancer services
John	• 87 years old - Male • Widow, lives alone, supported by son • Frailty, glaucoma and tinnitus	• GP Surgery • Pharmacy • Eye specialist
Michael	• 70 years old – Male • Lives alone • Retired • Has seizures, fainting and spinal problems	• GP surgery • Hospital admission • Neurology
David	• 84 years old – Male • Lives alone • Blood clots on lungs, high blood pressure and back problems • Bereavement during COVID-19	• GP surgery • Hospital admission

[4] Names have been changed to protect patient identity.

4. Findings

4.1 Patients and Public

This section presents the key findings from the seven in-depth patient interviews conducted in July-August 2020 and the public surveys undertaken by the CCG and HealthWatch in both Herefordshire and Worcestershire in August 2020. Full patient accounts, written as stories, can be found in Appendix D.

The key themes identified through the analytical process are discussed in the sub-sections below:

- Patients and the public worried about being a burden on the system when healthcare capacity was limited and refrained from accessing health services. Patients with specialist needs continued to have their specific health needs met; often this was through alternative means, for example remote consultations or home treatment rather than hospital visits.
- A range of individual preferences were shared for the use of remote consultations. In the main, most saw the benefit of continuing some types of appointments, for example non-acute triage and follow-up, as remote consultations after the pandemic.
- National communication for shielding and individual restrictions were confusing and hard to interpret. Local health services communication varied by service. The majority of patients and the public relied on their own ability to access the information they needed or consulted their own networks.
- Social isolation for individuals already suffering from poor health was another source of trauma. These emotional wellbeing needs were not always addressed, and the public perceived the access to Mental Health support to particularly difficult.

4.1.1 Patients and the public chose to minimise need to limit demand

4.1.1.1 Patients waited for healthcare services to initiate contact

Interviewee accounts highlighted the uncertainty that patients faced around how to reach their usual services during the pandemic and, as a result, waited for services to contact them. They were grateful for any contact they received, but once contact was made, a range of experiences were described for the mode of communication and the means of accessing the services they needed.

Almost all patients interviewed had experienced accessing the GP. The experience was largely positive, but examples were given about where access could be problematic due to the changes introduced. For example, one patient described having to listen to four minutes of a recorded message and having to have a pen and paper ready, with the option of choosing the triage/telephone consultation service only at the end of the phone message.

Those who had had telephone/video consultations with GPs described positive aspects of their experiences. For example, one high-risk patient went on to have regular contact with his GP as the GP was concerned about him having lost his wife to COVID-19 and having a daughter living with

cancer. This resonates with the H&W CCG survey (Sept 2020) findings, which suggested positive aspects of patients' experiences with GPs were a result of quick appointments and treatment, feel safe and reassured and friendly staff.

The Healthwatch Worcestershire (HWW) survey (Aug 2020) found services that were easiest to access were: Ambulance (82%), Pharmacy (78%), Hospital (A&E) (72%), GP (66%) and Maternity (63%). The services that people had needed but found difficult to access were: NHS 111 Phone (42%), Children and Young People Mental Health (41%), Adult Mental Health (38%) Therapists (for example, Physiotherapy and Occupational Therapy) (37%) and Dentist (35%).

4.1.1.2 Patients and the public were concerned about adding to the NHS burden

Patients interviewed were very understanding of the limitations in the services they accessed; they were grateful for the care received and reluctant to state anything negative or critical regarding their experiences. One patient who would usually wait to discuss her questions and concerns with her nurse specialist at her regular hospital appointment refrained from doing so at her home visits now, knowing that it was unsafe for the nurse to stay longer than necessary. She also did not want to phone to ask as that would make a 'big deal' out of it.

These perspectives were confirmed by the Healthwatch surveys: the main reason given for not accessing health care services during the pandemic was because the public did not want to put pressure on the service (as stated by more than half of all respondents); other reasons included fear of infection and feeling it was a minor complaint.

More specifically, the HWW survey (Aug 2020) indicated that 7% (122) of respondents had not been able to access support for their mental health or emotional wellbeing during the time of the first wave of the pandemic. The three most frequent reasons given for this were: do not know how to access support; felt they shouldn't access support at this time/others need it more; and felt that there is no support available and/or no point in trying to access this.

4.1.1.3 Individual resilience was relied upon to cope with social isolation

Most patients expressed some level of shock in their accounts of the pandemic and lockdown rules. Even those who reported strong family or support networks experienced some form of social isolation. Many of those interviewed lived alone and then had to further limit their interactions with others.

Patients at risk had either received correspondence from health professionals to shield or self-identified as high risk and shielded, to varying degrees, as a result. Changes were made to their lifestyles, keeping in-line with the guidance as best they understood, or could (not everyone had access to support for shopping or transport). The elderly, in particular, identified additional risks and were more cautious when going out.

Patients demonstrated immense resilience through tough circumstances, with many having to make drastic changes to their lives. Some tried to keep active and continued supporting themselves; for example popping to the shops or going for walks. When permitted they were grateful for the opportunity to meet family and friends albeit in a socially distanced way.

Whilst lockdown was difficult for all patients interviewed, with descriptions of feeling 'numb' and 'prisoners of COVID', it was especially difficult for those who had life-limiting illnesses and those who had been recently bereaved. Cancer patients described being 'robbed of time' and there was much frustration, anger, and sadness implicit within their accounts; the pandemic had further taken away the time and opportunities to do things they wanted.

Beyond the treatment for their cancer, neither of the cancer patients interviewed had received any additional mental health or wellbeing being support, but it was evident from their accounts that their CNSs were going above their usual responsibilities and being a 'Godsend' in providing social contact, reassurance and the crucial link to care. However, the support provided was limited to the patient's cancer needs and wider needs of the family were not addressed, for example psychological support in vulnerable family members as a result of lockdown.

Overall, it was difficult to get a good handle on the impact on patients' mental health and wellbeing as those participating did so to discuss their physical health. However, it was evident that many wellbeing issues had deteriorated, unaddressed. In the HealthWatch Herefordshire (HWH) survey (Aug 2020) 78% of respondents stated COVID19 had had a negative impact on their mental health.

4.1.2 Use of healthcare services was limited by safety protocols

4.1.2.1 Patients and the public were confused by national and local guidance

Patients expressed concerns about the lack of clarity and formal guidance about what they could and could not do, with government information highlighted as being very confusing. At the time of the interviews public rules were changing and becoming more difficult to interpret, interviewees were losing confidence and trust in the national communications and relying more on accessing information themselves (e.g. from newspapers) or others to keep up to date or translate information and guidance. The HWW survey (Aug 2020) found the top three most helpful sources of information were: national websites (for example GOV.UK, NHS.UK, MIND.ORG), media (for example television, radio or newspaper) and family, friends or neighbours.

Only 67% of respondents of the HWH survey found it easy to find information they need to keep safe. The combined HealthWatch surveys found that the topics people found most difficult to find information on was testing and use of masks, gloves and PPE. A notable number of respondents also find it difficult to find information regarding healthcare services (HWH, 23.4%) and managing existing health conditions (22.7%).

The HWW survey (Aug, 2020) found communication from the following services were most frequently rated as excellent/good: Pharmacy (73%), GP (71%), Hospital – A&E / MIU (62%), Children, Young People and Family services for example Health Visitors, School Nursing etc. (60%). Communication received from the following services most frequently rated as Poor / Very Poor are: Mental Health – Children and Young People (39%), Mental Health – Adults (39%), Hospital – Planned Treatment (22%) and Therapists – Occupational Therapy, Physiotherapy etc. (22%).

4.1.2.2 Alternative forms of consultations were acceptable in the circumstances

Patients who were users of specialist services – such as Cancer, Mental health and Podiatry – continued to have some of their usual consultations via alternative, remote, methods (telephone and video). These alternative consultations were appreciated given the circumstances, but for some patients there was a strong preference for reinstating face-to-face appointments once it was safe to do so. For others, the use of alternative consultations was linked with a good experience of the NHS. This was also a finding of the HWW survey: when respondents were asked what they would like to see continue, most positive aspects related to the appreciation of the use of telephone & video for GP / other NHS appointments (58% of positive comments).

This variation in individual preference was demonstrated in the cancer patient accounts. One reported having received bad news regarding her treatment options over a video consultation, but her disappointment was blunted by receiving the news in the comfort of her own home and in the company of her friend. Conversely, the other patient said her preference would always be to receive bad news face-to-face.

There were several risks presented regarding alternative appointments. Firstly, in remote consultations, some patients found it difficult to express themselves fully and felt this was limiting the ability of non-verbal cues to be picked up by healthcare. There was also a worry that these alternative consultations could contribute to existing or new anxieties/paranoia.

4.1.2.3 In-person healthcare drew attention to inequities in access

Interview accounts also revealed how the pandemic provided an opportunity for patients to utilise health services differently. For example, as pharmacy services were extended and they became more involved in the coordination of prescriptions, it provided some patients the first opportunity to use home delivery services from pharmacies.

Patients with specialist care needs continued to receive treatment and support according to their care plans. For example, treatment for both cancer patients who participated in the research was switched to home: one patient was shown how to administer her own injections and the other had a nurse that came to her house to administer them. Patients were satisfied with this as their preferences were taken into account.

Patients in receipt of home visits described how the measures followed by health care staff with regards to PPE made them feel safe and assured. However, they did find masks to be a

communication barrier, especially those who are hard of hearing. Similarly, those patients who had hospital-based treatment described feeling safe due the precautions taken.

Where in-person appointments were warranted but COVID-19 priorities did not allow them, there was additional anxiety and implications for longer-term need. For instance, one patient described the GP's inability to refer him for colonoscopy that was required. Another was unable to attend an eye appointment at the hospital due to patient transport services not being in operation during the lockdown. Correspondingly, the H&W CCG Survey (Sep 2020) found a key barrier to accessing health services was a lack of patient transport.

4.2 Primary Care

We have previously reported in full the findings from the primary care interviews conducted in April-June 2020 (Appendix C). Here we provide a summary of the key findings.

- Primary care leads quickly, proactively and collaboratively reorganised into Hubs to deliver services based on urgency of need and COVID-19 status. Individual practices followed, willingly and rapidly adapting to the changed way of working, with strong team spirit.
- This collaborative team working was made possible by the developing Primary Care Networks (PCNs) infrastructure; PCNs allowed primary care to bed in joined-up ways of working and as a result be more responsive and resilient.
- Support from national agencies was a source of disappointment and even anger for the GPs we spoke to. They felt let down on all aspects, including safety and guidance. Practices had to resort to personal networks to resource PPE, shielding lists were not fit for purpose and national guidance was late and/or confusing.
- The CCG support had been received positively: regarded as being most useful in providing IT hardware, training in software use, being an additional pair of admin hands, and for trusting GPs to lead.
- A collective sense of pride in the singular primary care voice has emerged from the crisis; primary care leaders were emboldened and empowered, ready to assume responsibility of future primary care services in their system

4.2.1 Need, demand and behaviour

An initial drop in demand was observed in primary care and this was assumed to be due to patients being worried about going to their surgery and making contact with healthcare professionals more generally. As a result, primary care become more proactive (including through social media) to communicate to their patients that they were open and alternative forms of appointments were available.

"*The long-term condition care, almost all of it's been postponed at the moment, although we're already starting to reintroduce nurse appointments, nurse telephone and video and GP appointments, so that's filtering back up now naturally*."

The offer of remote appointments was taken up and the number of consultations increased (although they remained below normal). GPs described an increased acuity of need and a backlog building for healthcare; they were using the capacity available to make plans for longer-term management of demand.

"*Because the demand will increase because all those people who aren't calling will start calling. What we have got to do is find a way of managing that demand, within the flex that we currently have……we are doing that and starting to do that more and more and more and talking about doing that more and more and more. And this has been a huge revolution, absolutely amazing*."

4.2.2 Primary care delivery in response to COVID-19

Primary care leads in H&W quickly, proactively and collaboratively reorganised into Hubs to deliver services based on urgency of need and COVID-19 status. Individual practices followed, willingly and rapidly adapting to the changed way of working, with strong team spirit.

"*We've got now a picture of the whole of general practice in terms of what could be offered and the internal sigh of relief I made once I saw the scale of the offer from general practices, amazingly generous offers that people made of what they would be prepared to give, if the worst came to the worst, made me feel much more assured that we would be able to meet whatever challenge came to us*."

Collaborative working across primary care was readily accepted as a way of working during the crisis, as staff viewed prior experience of merged practices and Networks positively. This collaborative team working was made possible by the developing Primary Care Networks (PCNs) infrastructure; PCNs allowed primary care to bed in joined-up ways of working and as a result be more responsive and resilient.

"*No one could have predicted it, but actually pulling networks together the previous year was really good timing. So you can imagine, in certain parts of the country, if practices weren't working together, you'd be trying to work together in the middle of a crisis, with no support*."

Practices were proactive in different ways in quickly managing their patients and their staff as clinical risks of COVID become known. However, with increased pressure on care homes and reduced ability to refer to secondary care, primary care viewed themselves as carrying much of the burden of healthcare need at the time of the crisis.

The adoption of technology in facilitating primary care delivery was seen as a revolution; GPs however cautioned against wholesale use of remote consultations in future primary care due to the loss of aspects of person-centred care and widening inequalities through digital exclusion.

4.2.3 System working to support primary care

Support from national agencies was a source of disappointment and even anger for the GPs we interviewed. They felt let down on all aspects, including safety and guidance. Practices had to resort to personal networks to resource PPE, shielding lists were not fit for purpose and national guidance was late and/or confusing.

"We've had to locally sort it out, haven't we, basically amongst ourselves…we've done it despite what's happened nationally and sometimes if it was a good idea they catch us up later on!"

In contrast, there was a collective sense of pride in the singular primary care voice that has emerged from the crisis. Primary care leaders were emboldened and empowered; and, ready to assume responsibility of future primary care services in their system.

"*I think the Clinical Directors are beginning to feel they want to be part of that conversation. The only question I guess is how big that table needs to be and how many people need to sit around it.*"

Local CCG support was reported to be, in the main, proactive to expected need, responsive to emergent need, and effective. GPs requested further support, from both the centre and their local system to sustain energy for change, especially in dealing with the healthcare backlog and acuity of need. This request and the wider lessons learnt are captured in Figure 1 below. They echo the principles developed by the BMA for both GP-led change[5] and restoration of wider NHS services.

"*We've seen some changes in the collaboration between primary community and acute care and mental health and those changes for patients need to stick for the future, i.e., it's not just us using videos but two week waits are being done now by video consultation, so I don't want to miss any of the changes across the system. It's not just about what GPs do, it's about how we work with other bits of the system.*"

[5] 'Trust GPs to lead: learning from the response to COVID-19 within general practice in England' BMA: June 2020 https://www.bma.org.uk/media/2652/bma-report-trust-gps-to-lead-june-2020.pdf

Figure 1: Recommendations for restoration phase in primary care, synthesised from interviewee accounts mapped to BMA principles of GP-led change[6] and restoration of wider NHS services[7]

[6] 'Trust GPs to lead: learning from the response to COVID-19 within general practice in England' BMA: June 2020 https://www.bma.org.uk/media/2652/bma-report-trust-gps-to-lead-june-2020.pdf

[7] 'In the balance: Ten principles for how the NHS should approach restarting 'non-Covid care'', BMA: June 2020 https://www.bma.org.uk/media/2487/ten-principles.pdf

4.3 Acute Trust/Urgent Care

Five interviews were conducted with urgent care staff based at Worcestershire Acute Hospitals Trust in July-August 2020. The key themes identified through the analytical process are discussed in the sub-sections below:

- Attendance for A&E fell in the initial phase of the pandemic but activity, which was both linked to COVID-19 and otherwise, rapidly returned. There was, however, ongoing concern that some emergency conditions such as chest pain were presenting late.
- Urgent Care teams, accustomed to a fast-pace of working, rapidly reorganised services to improve patient flow in A&E with organisational support. Changes were well received by staff and there was a desire to embed and sustain new ways of working and improved service delivery
- A high level of staff anxiety about the suitability of PPE provided was reported at the beginning of the pandemic. Professional opinion remained divided as to the appropriateness of the national guidance with regards to safety.

4.3.1 Urgent care demand

4.3.1.1 Demand for usual A&E services fell

Interviewees working in urgent care described the lower activity observed in A&E (up to 40% reduction) during the first wave of the pandemic. They perceived this to be the result of people 'holding themselves back' as they were apprehensive about attending hospitals, either out of fear of the virus or overstretching the NHS. Those working in A&E were concerned about the impact of non-attendance on people experiencing serious injuries, chest pain and cancer or pregnancy complications. Interviewees described late presentations of people with strokes and heart attacks as well as hip fractures.

"*I think my biggest concern was the chest pains have reduced. That was one of our top drops, so there was a drop of about 38% of people with chest pain not turning up. That concerned me because people were obviously scared to come into the hospital... My concern was that people with angina and other heart problems were just gritting their teeth in the community and choosing not to come in*."

Acute Trust interviewees reported that some of the trauma activity had reduced as "*people were not out and about"*. Minor ailments which contributed to inappropriate attendance at A&E were said to have 'disappeared', partly because other urgent care services picked up this activity.

"*There was a reduction in ambulances coming so what we found was paramedics were doing more 'see and treat', to try and keep people away from the hospital, we saw a 50% reduction, in self presenting.*"

There was of course much by the way of COVID-19 activity, with one interviewee recalling two incidents when the hospital was running at maximum capacity. There was a difference in opinion in whether the number of COVID-19 cases in H&W was higher or lower than expected but most Acute

Trust clinicians agreed that it was manageable. The challenge for A&E in managing the COVID-19 patient flow was in discerning who were symptomatic and who were atypical/'borderline' and then reassuring patients about their safe management.

"*I think it is that triaging process that was probably and arguably, the most difficult because trying to decide patients just coming in by ambulance and having to make quite a snapshot decision about whether we think this patient is COVID and if we do think they are potentially COVID, putting them into a bay which may have COVID positive patients in when they are potentially not. I think from a patient point of view, that was certainly the biggest concern that they had.* "

Most patients were described to be understanding or 'co-operative' of the situation and the changed health service they received as a result. A key challenge faced at hospitals was from patients wanting to be tested, contrary to guidelines, following attendance or discharge from hospital.

"*A number of patients raised it in the initial phase of COVID, they wanted to be tested. Patients who were going home, they were in the guidelines not to be tested and on that area we got quite a bit of challenge. The patients were quite unhappy and they wanted a test for sure and because of the shortage and the advice we were not to test on those that were going home*."

Demand for urgent care services had rapidly returned to normal, and at the time of the interviews was reported to be higher than normal. Interviewees were also expecting a second wave of the pandemic; given that it would likely coincide with the usual winter pressures there was some concern that some secondary services were returning to pre-pandemic activity and flow too quickly whilst other sectors were more cautious. Doctors were also concerned about the long-term health needs of patients recovering from COVID-19 and were familiar with the evidence suggesting that respiratory rehabilitation needs were going to be high and effecting other parts of the system.

4.3.2 Urgent care rapidly reorganised

4.3.2.1 A&E was rapidly reorganised to improve patient flow

There was a rapid reorganisation of the A&E departments to establish designated and defined areas which separated non-COVID patients from those that were suspected to have COVID, repurposing A&E and acute medicine areas.

"*That was turned around and all of the estates work was done within about 48 hours, it was a very, very quick turnaround because we had to make sure that we had somewhere safe to put those patients that were coming in with respiratory symptoms, we needed to be able to isolate them extremely quickly*."

Rapid clinical decision making, supported by increased clinical presence and a COVID phone alert (used by paramedics) helped place patients in the right places as soon as possible.

"*I certainly think there was probably more Consultant presence during COVID – I think it seemed to be. I think we anticipated it to be, I think other Trusts had significantly more numbers than we necessarily had so I think the rota was adapted, pre-empting that COVID would give us such a high volume of patients that we almost wouldn't be able to cope but I think if anything we overprepared with the rota which is not a bad thing at all.*"

Elsewhere in the urgent care system, overnight Minor Injuries Unit was closed; hours of operation reduced to the day to allow appropriate staffing levels, there was 7-day extended pharmacy support in hospitals to support discharges. Interviewees reflected that they had planned for the 'worst case scenario' and kept a 'tight grip' as the first wave unfolded. As a result, the changes in the urgent care system were perceived to have worked well, with interviewees suggesting some changes could even be adapted to post-COVID urgent care delivery.

"*I have learnt that we can use EDU for what it is meant to be used for - not for medical ward or surgical review. ED Patients should be going home in 4 to 6 hrs time which will increase throughput. It has been decided that AEC is not meant only for medical patients but can accept surgical and orthopaedic patients who can be discharged swiftly. We are in the process of making these changes permanent*."

Most notable was the view shared by interviewees that COVID-19 allowed great changes to take place in the A&E, to 'clear the decks', with no more patients in corridors or stuck in beds, with staff keen and working very hard to sustain these changes and not revert back to old practices.

"*Before COVID came along, it was normal to have patients in corridors, and patients on trolleys for 12 hours, and to have no beds, and then COVID almost cleared out the hospital. All of those medically fit for discharge patients were no longer stuck in the beds, and the community worked really hard to get them out and clear those beds for us and the corridor was cleared and nobody wants to go back to that, and so there is a lot going on now to prevent us going back to that situation we were in before*."

4.3.2.2 <u>Personal safety issues impacted on urgent care delivery</u>

A challenge for urgent care services in Worcestershire were the numbers of medical staff that needed to shield for their own health issues. This result in some changes to job plans, so that those who were shielding took on non-clinical responsibilities and those who could continue to deliver front-line care only took on clinical tasks. There was also additional cover by consultants from different hospitals in the Trusts and locums.

"*We do tend to have quite a lot of regular locums, people who have been there pretty much since COVID started and throughout, although they are technically locums, almost feel very much part of the team because they are there so regularly*."

For one interviewee the absence of the usual senior hands when the A&E was busy was described to be problematic for more junior medical staff, leading to low morale and potentially poorer patient outcomes.

There were mixed views regarding the appropriateness of the PPE that was provided to A&E staff. The distinction was in whether the 'plastic screen thing' or 'an inferior gown' were sufficient for those working in urgent care, leading some to query whether what was supplied to them was being rationed rather than evidence-based. Many staff had challenged the guidelines but were reported to have come to a shared clinical understanding for personal safety over time.

"We have had doctors and we have had nurses refusing to go into a COVID area to see a patient if they were not allowed to put the full PPE on. We have actually had a few of those, that didn't go into that area – it has been managing the department from the medical side and the nursing side, it was very challenging for the nursing senior management team and for us as well. "

4.3.2.3 Urgent care teams quickly adjusted to a faster pace of working

Interviewees reported good morale within urgent care teams, with different teams working together in a 'cohesive' way. Initial anxiety had given way to a high morale as teams responded to the challenge, however as time went on the tiredness of colleagues was noted.

"*I think we were all very focused, and I think in urgent care, things move fast anyway and we like to get things done quickly and so we were kind of almost in our element because things were moving and decisions were being made, and we could get things happening. It was actually quite exciting, I suppose, we all like that fast pace, so I think our morale was quite high because we do like a challenge and we do like to rise to it.*"

The management and admin teams worked flexibly from home with some redeployed to support the Trust's COVID control centre as normal tasks for managing an A&E (for example breach analysis) were no longer required: "*paperwork almost disappeared*". For those that could work from home, including shielding clinicians, the access to laptops and VPN had 'revolutionised' ways of working, especially in the ability to virtually attend meetings and communicate.

4.3.2.4 Changes in urgent care were supported by the Trust

Interviewees welcomed the training provided by the hospital and colleagues, for example the donning and doffing procedures for PPE including the use of the full respirators with hood as the process was complicated and not easy to quickly do in an emergency. Interviewees reported the need for continuous support for infection prevention and control due to rapidly changing understanding of COVID-19 and turnover of guidance.

"*Certainly, the PPE side of things was a vast change and that sort of goes without saying really. I think trying to keep on top of how the infection prevention guidelines changed, so there were a few times where either myself or one of the other members of the team would liaise with the infection control team and they would often come down to the department to explain what the newest update to the guidance was. "*

Interviewees were complimentary about the organisational support they were receiving for working differently, including from medical colleagues in other specialities. especially in decision-making without the 'red-tape and forms' and thankful for the new oversight by their Trust.

"*We are seeing positive impact of the changes, there is above average performance as a Trust because practice has changed, we have broken old habits and practices. The challenge was so big that the barriers melted away. I wish we could keep the behaviour we have been able to acquire during this challenge – it is possible to keep this for good*."

4.3.3 System working for urgent care delivery

4.3.3.1 *Partners had come together to deliver and effective services*

Urgent care staff described that the system partners had worked very well together, and the combined response had shown what an effective urgent care system could look like. Their worry was that with fatigue setting in, decisions to embed changes would be made too late.

"*I think I would see the biggest challenge now is just attitude, and it is making sure that because we are all tired, everyone across the whole system-wide network is tired, of us kind of just wanting to take that breather and then you know we do fall back into people in the corridors because we haven't made a decision fast enough*."

Interviewees reported that the CCG had been very supportive, providing funding for an additional doctor to cover evenings and night and rapidly agreeing to a Primary Care Navigator role in the A&E. Relationships and ways of working with the Ambulance Trust was also said to have improved.

The national communication for accessing healthcare services, particularly A&E for the next waves of the pandemic were suggested to be in need of improvement, to ensure those in need of emergency care attended more appropriately. Doctors were also keen that the government recognised, in a meaningful way, the contribution that NHS staff had made in responding to the crisis, especially knowing "*our colleagues were dying*"

4.4 Community Nursing

Eleven community nursing interviews from across H&W were undertaken in April-May 2020; the findings described below demonstrate the rapid reorganisation and adoption of a changed community nursing model to deliver care in response to COVID-19. The key themes identified through the analytical process are discussed in the sub-sections below:

- Community nursing leads had to plan innovatively, prioritise services and reorganise care, bearing in mind that the current reduction in demand would give rise to higher acuity of need.
- Changes to community services were made quickly and in the absence of organisational and system barriers.
- The use of technology to deliver community services divided opinion. However, nursing leads saw the benefit of digital communication in their ways of working.
- Joint-working across organisational boundaries improved during the pandemic, however community nurses' experiences of working with GPs varied.
- Community nursing leads worried about the safety of their staff seeing patients face-to-face, given they had different guidance around safety compared to other clinicians; for example, in the use of PPE by GPs.

4.4.1 Delivery of patient care

4.4.1.1 Reduction in demand was expected to give rise to higher acuity of need

The demand for community health services was reported to have decreased at the start of the pandemic due to a combination of factors. Firstly, patients were anxious of direct contact and refused to have community staff visit them in their homes due to fears of catching COVID-19. However, frequent communication via telephone was believed to reassure patients. Secondly, hospitals discharged patients with rehabilitation needs in expectation of increased COVID-19 bed use, with the expectation that these needs would be met at home or in care homes.

At the time of the interviews, there was some concern expressed that rehabilitation at home might be inadequate. However, most nursing leads were in agreement that the preferred option for future patient-centred rehabilitation was via community multidisciplinary teams and that the pandemic had provided the opportunity to improve this aspect of care delivery.

"*I guess because we had some success with rehab-ing patients at home, and they haven't had to go into a rehab bed, I do wonder if we will result in having a decrease in number of rehab beds available. I wonder whether the acute will start discharging patients' straight home, with community input.*"

Thirdly, community nurses worked with GPs to prioritise the needs of patients under the care of community nurses, assigning patients to either urgent treatment/support or routine care that could be postponed. This approach created anxiety for community nurses around the future backlog and increased acuity of need however, on the whole, patients were reported to be grateful for the access to healthcare professionals they had, even if it was limited to phone calls.

"*I think generally people are just grateful that we are visiting. I think a lot of the time they're grateful that we're at the end of the phone, so when I'm doing some more of the neighbourhood team type work with the community nursing teams, answering the phone to patients, I think they're just grateful that there's somebody at the end of the phone.*"

For some community health services, routine work had continued as business as usual but with the additional observation of strict infection control measures. In other services, where activity had decreased, it was welcomed as an opportunity to safely managed the changed delivery of care.

"*Yeah, it's difficult isn't it to – you know, I'm pleased that they've had their workload reduced, because I don't think they would have coped of we'd have had more visits with the amount of worry at the time as well.*"

Community nurses were expecting that in the backlog created there would be a higher level of need in patients, including those that were newly diagnosed much later in their illness. A demand challenge that was emerging for community services was in the rapid increases in urgent referrals for patients who were recovering from COVID-19.

"*It seems that physio work initially was quieter, but then actually they've had some influx over the last few weeks, there's been a lot of patients in hospital during the peak time that have been really poorly with COVID, and then they're coming out, and they've got quite a lot of high needs, in terms of therapy and rehab.*"

4.4.1.2 <u>There was new appreciation of the work of care homes</u>

As care homes were said to be reluctant to let community staff into care homes for face-to-face treatment, there were three options for community nurses to deliver care: self-care, encouraged for residents who had the capacity; delivery of care by care home staff who were first trained remotely to deliver basic care such as wound dressing, insulin management, falls care and end of life care; and, clinical consultations via telephone or video.

"*Actually a lot of the care homes don't want us in there unnecessarily, you know, several of the care homes that I've been liaising with, you know, actually went into lockdown pre 23rd March, and have actually said 'well, you know, we'd like you to do this or we'd like you to look at that but I don't want you to come in and do it, let's do it via a Webex or we'll email you a photograph and then you can give us an opinion on what you think we should be doing.*"

The new support offered by community nurses as a result of the pandemic response brought with it better insights into how care homes operated and respect for the staff who worked within them:

"*I think if we'd have known about the homes, and got those relationships in the first place, we could have potentially done more. But actually, what this has highlighted to me, is how little we know about our care homes and how self-managing they are, the ones that we have got patients in. And you know, some have concerned us on our way, as well as being very amazed by some of the really good work that care homes have done.*".

4.4.2 Changes in the community nursing model

4.4.2.1 *Decisions were made faster without the usual system barriers*

Community nursing leads described the overwhelming fears and anxieties their staff felt at the beginning of the pandemic when delivering face-to-face care to patients in the context of changing guidance, including in the use of PPE.

"*Right through to teams on the ground who, when they were first told you've got a COVID positive patient, yeah were terrified, and their experience of using PPE and of course all of the shift in guidance of PPE – you know all of that has an impact staff welfare and morale.*"

Despite the fear, community interviewees were in agreement that their services had proven *"amazingly adaptable"*, with capacity and capability added where needed, often through redeployment, for example through community nursing support for testing and swabbing at care homes. The pandemic had challenged individuals to think differently and encouraged a proactive team approach to enacting rapid changes, enabled by a significant reduction in the level of bureaucracy in the system.

"*We've just made so many positive changes in the six weeks. I know it's been COVID and I know it's awful – I suppose because you've pulled out all of the bloody authorisation.*"

This flexibility in ways of working was not just limited to community teams but was described to be cross-organisational, which was recognised to have future advantages for integrated care delivery especially via PCNs.

"I think one of the biggest things for me has been the almost overnight shift in people's perceptions. So normally when you say "Oh let's do this" and you're kind of across multi-organisations, there'll be somebody that'll say "Oh no I can't do that because my organisation says x, y and z" whereas now that just isn't a barrier, which is fantastic, and definitely what we need in terms of supporting our development of our Primary Care Networks, and our integration of working."

4.4.2.2 *Technology enabled the delivery of non-urgent community care and efficient ways of working*

The widespread introduction of telephone and digital consultations in response to the pandemic had allowed community nurses to trial delivery of care by remote means. For example, some routine

reviews and non-urgent therapies were taking place via video and telephone, community nurses were keen to retain this going forward. There were, however, concerns that many community nursing functions, such as such as bowel and bladder continence services, were not amenable to virtual delivery because they required physical examination, or they were conditions that needed a sensitive face-to-face consultation. Community staff feared the loss of the 'human element' in virtual consultations as well as the creation of inequities in access for specific patient cohorts.

"*Partially it's around the client group that I generally manage, so they do tend to be older patients who are generally more frail, and whilst I'm not sort of saying nobody of that age group uses technology, they do, but my experience is that they'll happily talk to you on a phone but they wouldn't want to be doing anything any more technical than that.*"

There was more enthusiasm for the use of technology to support ways of working: to catalyse the building of new relationships; enable integrated working; and facilitate communication across a wide geographical area. Virtual multidisciplinary teams (MDT) meetings, involving community nurses, social care, PCN leads, neighbourhood teams and end of life care teams were given as an example of having a positive impact in the delivery of patient care as a team.

"*Definitely technology has helped. Teams has been phenomenal for me. So, prior to COVID I would have spent a lot of my time traveling to various meetings in various venues, and losing a lot of time to be quite honest with you. I have interacted with people from all over the county, which I would not have been able to have done beforehand.*"

4.4.3 System working, local/ national support and communication

4.4.3.1 <u>The relationship of community nurses with GPs varied</u>

In the main, community nursing interviewees reported that they had been well supported by GPs, for example in providing advice on the prioritisation of care, and in reducing non-urgent and routine care. This had brought an added benefit of raising awareness of the work of community nurses, which was serving to improve the working relationship with primary care.

"*I actually think it's probably a little bit more heightened now, you know, the GPs review the work lists that we have and I think they were more aware of all the stuff that we do.*"

The increased awareness also made community nurses acknowledge differences in the guidance for, and access to safety equipment of, different healthcare organisations; as community nurses they were observing GPs seeing patients in PPE, whilst they were going without.

"*But that was quite tricky because obviously GPs took a different route and you know they were going out all PPE'd up. And it just wasn't available, it just was not available to us. That was quite difficult at that time for me, I was struggling with that decision really, because obviously you do want to protect your staff.*"

Differences in working style and relationships compounded the challenges of collaborative team working between primary and community care during the time of the crisis. When the interviews were conducted, community nurses requested more support from GPs for caseload review, palliative care, and verification of death.

4.4.3.2 There were mixed views of national and CCG support

Overall, community nurses reported more trust in the overall system and that this was conducive to integrated system working. There were better relationships between commissioners and providers, and more proactive system-focus on the needs of patients.

"*It's changed those relationships to the positive. And I think focusing on a crisis is good for everybody, because you know, for the majority of people you end up pulling in the right direction., but I think there's a degree more of trust.*"

There was criticism of the national support, especially for the guidance issued for delivering community services safely. Perspectives on this ranged from the information being provided at a national level being overwhelming, to being inadequate. More specific guidance, for example around the changes related to delivering care at home and the prescription of drugs, were found to be more helpful.

"*I think there's just oodles of information out there and it has been very much up to you as an individual to how much you take on-board, so how much you want to Google and how much you want to read.*"

4.5 Social Care

Five interviews with front-line social care staff were undertaken in August 2020. The key themes identified through the analytical process are discussed in the sub-sections below:

- Social Care had to rapidly change their service model to respond to the increased demands of COVID-19.
- External care services cancelled home visits, most social workers, however, continued with face-to-face services in patient homes.
- Social workers took on additional responsibilities, working extra hours, sometimes in the absence of peer/team support, which impacted on their health and wellbeing.
- Wider use of technology to enhance staff communication was viewed positively.
- There was perceived to be an overload of general communication targeted at social care, but a lack of relevant guidelines – for example, for temporary adult social care funding.

4.5.1 User-centred social care delivery was challenging

4.5.1.1 Face-to-face visits were the preferred option to meet service user need

Three of the four social workers interviewed continued to deliver face-to-face support to their services users. This was largely driven by the needs of the service users; social care professionals found phone or video use hindered communication or were inappropriate, particularly for the vulnerable, elderly and people with complex needs or disabilities. However, video calls to involve families and carers were recognised to have added benefits.

"Service users don't find technology easy. I need to understand them. It's very difficult to explain to them over technology. They could think I was on the television!"

In line with guidance, social workers used PPE when visiting service users. However, face masks came with their own disadvantages when communicating with those with hearing difficulties or visually impaired. More generally, they impeded trust in the professional and service user relationship resulting in "*distressed*" service users.

"I used to take off my mask outside the window and show my face first. You want them to trust you, to get that with mask is difficult because you look like people in white coats and they expect you to just cart them away somewhere. A lady was being aggressive, and I made the decision to take my mask off because I thought it might improve her behaviour towards me."

4.5.1.2 Future demand for social services was expected to be more urgent and complex

As lockdown came into force and health services prioritised need, social care staff reported inappropriate influx of service users with mental health needs. This increase in demand was later compounded when existing service users, with minimum contact to other social opportunities or support due to lockdown, deteriorated in their own mental health and wellbeing.

"There was a gentleman who had the onset of dementia and with isolation he hadn't had the routine and missed social interactions with others. He had taken an overdose. A lot of people are feeling low, worried and there are concerns when activity will resume."

Social care had concerns regarding the backlog and escalation of need being created in service users. They also had concerns around safeguarding, especially with limited ability to make use of informal cues for care needs (i.e. usually gained when visiting a service user in their normal residential settings). These concerns were based on what social services were already observing.

"There were 16 deaths on the caseload during lockdown, some directly attributable to COVID-19, others as a consequence of deteriorating physical health. In the same period last year there were 4 deaths. It is not possible to identify the actual reasons for this increase, whether it was worry about seeking medical attention, reduced continuity of carer or other reasons."

4.5.2 There were rapid changes in social care delivery

4.5.2.1 Social workers were challenged by the increased workload

The workload of social workers increased dramatically for a combination of reasons: the rapid discharge of patients from hospitals meant that assessments that were usually conducted in hospitals had to be managed over several meetings and within COVID-19 guidelines; external care agencies cancelled previously agreed packages of care for service users; and capacity was reduced as staff were off sick or shielding.

"The volume of work has been insane. The other day I had 18 patients of mine and 7 of my other colleagues. I was only in 4 days. I was thinking 'how am I going to manage?'"

Where redeployment was possible in social services – for example, day centre staff were redeployed to provide community support, welfare checks and supportive phone calls – it was welcomed as it enabled the continuation of support for the most vulnerable service users. However, in the early stages it had required some rapid and additional work to ensure appropriately trained staff.

"Staff in day services were deployed to community support which was beneficial as they already had relationships with a significant number of the service users. This involved additional work to establish appropriate and safe working practices".

With increasing demands and concerns around capacity, many services moved to seven day working. Staff reported that they immediately 'mucked in', were flexible and adapted immediately to the new demands imposed. They worked overtime, on weekends and were keen to be part of the rapid response, despite their own COVID-19 anxieties.

"Everyone helped each other and got on with it. You want to make an impression. You see everybody else go for it, helping out and you want to be part of that".

As the initial response to the crisis passed, interviewees became more concerned about burn-out and the emotional toll on staff, recognising that the current ways of working were unsustainable.

"Expectations have been raised in relation to rapid response at both system and individual level. I'm not sure how this can be maintained. Staff have worked beyond their contracted hours to support the safety and wellbeing of service users this isn't sustainable long term".

4.5.2.2 <u>There was rapid decision-making and the wide adoption of technology among social care teams</u>

Interviewees described how the focus of their care delivery had changed to prioritise community and independent living support for service users; and that this had been made possible through a rapid decision-making approach with the absence of usual bureaucratic practices and system barriers.

"*Many processes have been put on hold in favour of pragmatic approach, 'let's get this resolved!' We just did it without having to agree through internal business frameworks*".

Outside of service-user interaction the use of technology was widely adopted and perceived to be a catalyst for more effective team working and a better use of resources. For example, regular video calls allowed teams to discuss caseloads, conduct risk assessments and provide mutual support to each other.

"Staff, system partners and providers have embraced technology, the ability to rapidly bring individuals together virtually to respond to challenges has been hugely beneficial".

There was a desire to retain the use of technology in the future as a supportive tool in the delivery of social services, recognising the flexibility and productivity it afforded staff.

"Social workers don't need to go into an office. Flexible working and home working will support women with caring responsibility if they can display that they are productive. It will provide a better workforce and help with workforce retention".

4.5.2.3 <u>Health and wellbeing needs of staff were inadequately addressed</u>

The experience of social workers with regards to support from their wider teams for their own health and wellbeing differed. Whilst there were examples given of *'looking out for each other'*, there was a view that this was an individual responsibility and not one for the team.

"I am a resilient person and I can say that I have had enough support. To some degree, you have to be responsible for your own health and wellbeing. We have a Tuesday call every week with the service manager and we can have a good moan and she asks if we are fine. We have a peer catch up and we swear a lot!"(SC5)

Others felt that more support was needed especially with regards to home working; applications for office working had been denied and a lack of responses to messages left on staff support helplines were reported.

4.5.3 There were mixed views regarding national and local support

4.5.3.1 *Health and social care support were delayed for service users*

Social workers found the decision taken by many nursing home and residential units not to allow physical access to other professionals problematic. Examples were provided of delays to mental capacity assessments, rehabilitation and therapy treatment and there was concern around the impact of this.

"We have a lot patients who have cancer. A lot of the routine follow appointments have been cancelled, they have fell more poorly and they had to receive fast track care in the end. I wonder if they received their routine appointment whether they would have had more treatments and their life would have been extended".

There were mixed perspectives on whether those rapidly discharged from hospital were adequately supported in the community. For some, the additional support given to individuals to stay temporarily with friends and family and the purchase of capacity at a local hotel and refurbished care settings was sufficient. Others queried whether the medically fit status would be compromised with limited access to treatments and rehabilitation.

Social workers also had mixed experiences of accessing and using PPE, ranging from adequate access to PPE with training on how to wear it to 'woefully inadequate' in the initial phases. Social workers felt it uncovered the challenges social care sector faced: *"they were not recognised as priority recipient by either the NHS or local authority."*

Where there was limited access to PPE, it resulted in compromises in service delivery as care could not be provided safely. Even where PPE was accessible, the process of acquiring PPE was perceived to be so complicated that staff resorted to purchasing their own or used from elsewhere, for example nursing homes:

4.5.3.2 *National guidance for adult social care did not meet the needs of front-line staff or service users.*

National guidance was provided from various professional bodies including Local Government Association, Association Directors of Adult Social Services, CCG, British Association of Social Workers and NHSE. As a result, many social workers felt there was an information overload and struggled with

finding time to read it. It was also not perceived to be relevant to their frontline service user responsibilities.

"Having time to read all that information while we doing over time and really busy was difficult. What's more important, getting back to a service user who has called three times or reading government guidelines? We are not getting much breaks at home".

The national temporary COVID-19 funding for adult social care meant placements to nursing homes were expedited without the need for the usual financial assessments. There was also a delay in issuing clear guidelines for service users and providers around the temporary funding., which resulted in one social worker resorting to writing her own guidance to outline the process for service users. There was also a general concern around the sustainability of high-cost temporary placements.

"With the funds, people have been going to high cost placements, places they wouldn't have been going to normally. What's going to happen later? Are they going to stay there or are you going to be moving them? I don't want to tell them that they will have to move later on".

4.6 Care Homes

This section synthesises the accounts from eight interviews with care home managers (n=5) and health and care commissioning staff (n=3). Two nursing and residential homes (with a total of 116 and 54 staff) and two residential homes (100 and 31 staff) participated (for one setting, both the Manager and Deputy Manager participated).

Of the four care homes that participated in the interviews, only one had a COVID-19 outbreak (10 cases reported). This means that the experiences described below are potentially more biased towards positive experiences although, as one care home manager stated:

"*I just get fed up with hearing the negative stories about care homes which I am sure there are many, but you don't hear the positive ones so much do you?*"

The key themes identified through the analytical process are discussed in the sub-sections below:

- Care home managers galvanised their staff and enhanced team working to focus their efforts on their residents' health and wellbeing; in the absence of external visitors, care home staff tended to residents' emotional needs
- Care homes introduced strict infection control measures for staff including core team members that moved into the site over the peak of the first wave.
- Involvement of their staff in MDTs was welcomed by the homes; nursing managers especially felt the profiles of homes and the credibility of their work to be recognised within these meetings.
- Care homes needed specialist and remote clinical support from the system. There was limited resource available in commissioning organisations to provide this unexpected intensive support.
- The commissioning of future care home services by the system is expected to require greater alignment of resources and better oversight than currently exists.

4.6.1 Care homes focused on keeping existing residents safe

4.6.1.1 *Care home staff took on additional roles to compensate for the absence of external visitors*

Care home managers described how their staff had catered to the emotional needs of residents, fulfilling the role of families as care homes closed their doors to external visitors. These needs were further heightened because of fears of the virus or related anxieties.

"*The care staff became the residents' family and they have sort of come to them with queries, anything that they usually ask their relative, they would be able to ask the care staff so they got quite close with the care staff on a one to one basis. "*

As a result of the 1:1 support, absence of external disruptions and improved infection control the health of most residents was described to have improved through the lockdown. Managers were however worried about the longer-term decline in mental health and wellbeing of their residents in the absence of physical contact with their families and other visitors, especially if there were repeated waves of the pandemic.

"Going forward, that has been our main priority, more so than anything else really, just trying to get them integrated again and get them socialising with each other."

Interviewees reported that their staff had compensated using their own skills for some of the '*massive*' changes they had to introduce to residents' daily activities such as: rotation between residents for use of the dining room at mealtimes; no weekly minibus trips; reduced group sizes or no grouped daily activities; no externally led activities.

"The main thing we have done is 1:1 activity which have improved no end which isn't a bad thing. We have had to draw on our staff really and amazingly, we have found skills in our team that we never knew we had. So, we have come up with singers, comedians, lots of different things, writing poems, creating newsletters so residents have that fulfilment really still."

4.6.1.2 <u>Face-to-face contact with family was being introduced slowly</u>

Care homes closed their doors to outside visitors before the official lockdown, with one manager recalling it was when "*Boris Johnson made the announcement that anyone that was vulnerable needs to shield*". Care homes managed the subsequent interactions with family members via video and phone calls. Some homes had prior experience of this with residents' relatives living abroad and were able to use this understanding to plan ahead, setting-up a timetable of slots based on equipment available to them. In addition to phone and video calls, homes reported using digital newsletters and photos as a means of keeping in touch; one was particularly creative in their use of Zoom to maintain existing activities.

"*We also used to have a vicar that would visit and do a service every week and we couldn't do that, so we do that over Zoom conference every Friday and relatives at home can join in and attach to that so that has been a really good positive thing. It is not all negative in this, we have come up with solutions to things that have worked really well.*"

At the time of the interviews in July-August, most care homes had reopened for garden visits for those who were not nursed in bed, and residents were reported to be content with this.

"*We have seen some return to normal as we have been able to do the visits in the garden – that has been wonderful for some of them.*"

Visits were managed under strict guidelines including pre-booking of carparking, a maximum of two visitors per day, temperature checks of visitors and the clear expectation that all infection control guidelines are adhered to. Allowances for building visits were only made for residents that were at the end of life. These allowances varied based on the setting of the home, but in all cases required the wearing of PPE at a minimum and the adherence to infection control measures.

"Unfortunately we had a resident who was end of life, and fortunately his room was right next door to a fire exit, so he was able to have the family in, follow all of the guidelines and they were able to sit with their dad until he passed away. If anyone was end of life, we would make every effort to be able to have family in to sit with their relatives in their final moments."

4.6.1.3 <u>The decreased demand for care homes was impacting on the business</u>

Rates of occupancy in the care homes at the end of the first wave of the pandemic varied, for one it had remained the same (good occupancy) but for others it had either gone down or remained low.

"We have been really lucky because we have had no deaths, we have been really well as a home and we have maintained our occupancy. So we have had one admission throughout all of this process and the only thing that changed is the isolation period."

At the beginning of the crisis, care homes had made a decision whether to continue to take new residents. Some had only allowed new residents if the infection control procedures such as '*two weeks isolation and crash barrier nursing in their rooms*' could be followed.

"Intake of residents has not changed, we decided quite early on that we were not going to stop admissions into the home, we would just put precautions in place because we didn't want to leave the pressure on the hospitals, so we didn't stop taking admissions".

Managers at three of the care homes we interviewed described only recently having re-opened up their general admissions process, preferring to concentrate on keeping existing residents safe. The early experience of opening up for admission was a delay in enquiries; there was some reticence as families were still making up their minds.

"We haven't had many enquiries, that's been one thing that we have really struggled with, is new relatives or the local authority making calls for placements in the Care home, but we have now got a procedure in place for new admissions, so we are now taking admissions."

Some managers were confident that demand for care homes would rise as families came to terms with severity of their relative's care needs and their ability to meet those needs.

"*Yes, I think demand will start to increase again. Already this week, I have done four assessments, so we have got potentially four admissions this week, because I think people have held off and held off and everyone of those admissions is somebody in crisis. They have been managing Mum or Dad at home for as long as they possibly can and now, they are just desperate*."

Whilst some savings had been made by care homes during the crisis, such as no agency fees and reduced activity costs, care home managers were very worried about the future sustainability of their business. One home was already running at a loss with the lowest occupancy (60%) it had in several years. Managers described making cuts to staffing from a budgetary point of view and considering which 'nice bits' to cut from activities as finances become more 'pinched'.

"I think that businesses and Care Homes are going to struggle – that is definitely probably one of the biggest worries as a consequence of COVID and then if the business struggles then everything else underneath it starts getting looked at. If you have a business model, you have got to look and link that to staffing, food everything, so I am waiting, we have had no pressure at all from my company around occupancy or about any of that yet, but it will come at some point and I am wondering what that will look like when that comes."

4.6.2 Care home staff fully committed to their roles in exceptional circumstances

4.6.2.1 Delivery of care was under considerable personal duress

Care home managers reported constantly changing staff morale with initial fears and low morale giving way to adrenaline and high morale, dependent on changing circumstances. Anxieties were most difficult to manage at the early stages especially with some staff opting to leave and some staff shielding. At one home, the decision was taken to have a dedicated, reduced core team on the premises so as not to put all staff members at risk.

"*For the first few weeks it was really sketchy and changeable. You would have one person come in on shift that would be terrified and that would bring the whole shift down*."

Managers described their own fear of having COVID-19 in their homes alongside a sense of personal responsibility for, and attachment to, their residents that had driven them to take action to protect their residents.

"*This home is my responsibility; I care about every single individual here – residents and staff and it would be heart-breaking and that is the fear for me. And we would get through it and I know we would cope but I just don't want it here. We have got residents who we have cared for five years and you do become very close to them, it is one of the new realities of what we have to face now but it is not a nice reality, it is very frightening*."

This fear appeared to be more heightened at residential homes compared to nursing homes (although this is a tentative conclusion, from limited interviews), as they felt insufficiently skilled to look after resident's general health within the confines of lockdown.

"But again, because we are not medical staff, it leaves us sort of quite anxious for the resident's health, because we don't want to be sending them into hospital you know if it isn't required and if they can

have treatment at the home, the cross contamination of the resident going into hospital and then coming back and the impact of their mental wellbeing when they have to stay in isolation for two weeks, it can massively impact on their mental wellbeing as well."

At the time of the interviews, managers reported that they and their staff were exhausted and '*mentally drained*'; they were attempting to make the most of the respite that they currently had post-crisis. From their perspective the situation seemed *'endless'* as most were expecting, and fearful of, a second wave.

"That is not underestimating the fact that I know that they are really tired, and I know that everyone is just waiting to see if it comes back and I know they are frightened, because the thought of doing it again makes you take a moment and think oh my god, how we can do that? But if it comes, it comes, and we will."

4.6.2.2 Staff supported one another to deliver safe care to their residents

Care homes instigated a range of team activities to maintain staff morale, this included wobble rooms, daily huddles, games and quizzes, gave gifts, chocolates and wine, and shared positive feedback/praise as staff group text alerts.

"We have had ups and downs but because we have supported each other and allowed for people to have wobbles.....We have dealt with things at the time, and also as a manager showing my vulnerability so saying do you know what, I am not coping very well today so it gives them almost a green light to say do you know what, that is fine and they have been so supportive, not just to me but to each other and I am so proud of them all."

Managers were proud of what their teams had achieved and described the '*comradery*' and a '*sense of togetherness*' in how they worked; a team spirit that that had previously been absent. At one home, staff sick rates were described to have fallen. Managers described how staff communication had reassured staff and allowed them to commit fully to team working.

"I think that because we have concentrated so much on communication, I think the team are with us. I do remember in the first four weeks, coming into work with a constant fear that the entire staff team might walk out. When we first went into this, we had all heard the story in the news in Spain where the entire Care Home staff left the residents and there was a moment I think about two weeks in, where I thought I can see how that could happen if you allow the fear to spread, but actually everybody has been amazing."

Staff also took on tasks that were different to their job role to allow '*all hands-on deck'*, for example carers took on cleaning tasks when external cleaners were no longer allowed on site.

"*And then probably at the beginning of May, over the peak, well there was ten staff all in all, that moved into the care home for three weeks and at that time, it was, no staff were allowed in and no staff were allowed out, so we had shopping delivered by other care staff. We carried out a variety of different roles,*

such as the cleaning staff were not in lockdown with us, so we would take on the cleaning, making sure that everything was being adhered to, in terms of PPE and sanitising everything."

In other homes there was increased involvement of wider staff in decision making; care home managers who were nursing leads had learnt the value of engaging all staff rather than 'sheltering' them from business decisions. They were hoping to continue this involvement post-pandemic.

"They have helped us to make decisions – they have been involved like when we asked them what they wanted to do about agency going forward. The fact that they made the decision to not have any agency staff in the building meant that they were all committed to doing extra shifts and they did them. I guess that involvement in some way has been a pivotal thing that we will definitely be taking forward."

4.6.2.3 Staff adhered to strict rules for infection control.

Daily life at the care homes at the time of the interviews was still subject to strict infection control measures, these varied depending on the home, but tended to affect staff more than residents in order to keep '*life as normal*' for the residents. This included: daily temperature checks of all staff; staff changing into uniform only on site; frequent hot spot cleaning through high volume areas; designating different floors/area as separate households; use of appropriate PPE; and establishing isolation units for any new admissions or symptomatic residents.

"None of the us go to work in our uniforms now, including the management team. We get changed here and temperatures are documented, staff wash their hands, and get changed. We only get changed in a particular set of bathrooms that are routinely cleaned more often than the others. We are wearing professional PPE all of the time."

Managers reported that social distancing and mask wearing had become the new normal, especially as it came with the added advantage that the general health of residents improved.

"Not surprisingly, our infection control rates have dropped with everything, we have never had residents so well. So yes, it works obviously. Our residents have been well, we have not had colds or general niggles like you would do throughout the last five months. Our wellbeing checks that we do on our residents are just really good."

4.6.2.4 Technology and training allowed staff to discharge roles to their full potential

Homes were very grateful for the iPads they had received from the CCG; one had also received phones from a charity. This additional, improved access to technology had allowed residents to receive healthcare remotely (as well as keep in touch with relatives – described earlier) There was agreement that without the use of technology, the ability of homes to deliver care to their residents would have been compromised. For the future there was acknowledgement that some aspect of technology facilitated care delivery would remain, for example in Consultant reviews but not for new admissions where face-to-face assessments worked better.

"I mean right now, a lot of what we do is over the phone, if we can do video consultations, if we manage to get a signal, we've done video consultations and a lot of using technology, which in one way has been brilliant and in another way, it has it's pros and cons… I think in the future, I don't think it's going to change dramatically, but I don't think it's going to go back to what our normal was."

Managers reported that staff had kept up to date through eLearning for the usual competencies such as safeguarding and health and safety. Additional COVID-19 related training was also provided, often one-on-one, on a range of aspects including infection control, PPE wearing, barrier nursing, wellbeing and mental health resilience, and in the use of technology.

"I have had to do a lot of training around the use of the iPad, and how to actually connect with the doctors – a lot of staff haven't done that before which was quite a surprise I suppose. It just sort of happened overnight. I was here at 8 o'clock at night showing people how to use an iPad." Whilst external trainers were used to deliver digital training, at one home nursing leads had delivered the training themselves, including an infection simulation. The training had been received so positively by staff that the home was re-assessing its delivery of training for the future.

"Very early on, we did simulation PPE training so we set up sessions and we had almost, one of the staff would act as a potential resident who may be infected, and we set up our potential PPE station and how you would gown up and make sure you are putting the items on in the correct manner…The feedback that we've had is this is better than any training that we get."

4.6.3 The pandemic had increased the value of care homes in the local system

4.6.3.1 <u>Care homes were well supported by corporate teams and care homes' networks</u>

Care homes reported minimal challenges to accessing PPE and counted themselves as '*lucky*' in having a good supply of PPE. Homes that are affiliated to a care home provide, benefitted from the parent company sourcing PPE on its behalf.

"*Basically they had to set up a whole team of people that work from head office with that as their new jobs (as I said now everyone is going back to their normal jobs), but their whole job for basically the whole of lockdown was sourcing and buying PPE for the company."*

Independent homes had been more anxious, but over time reported being confident in their ability to source PPE through the government portal, the local authority and national care home managers networks.

"The Skills for Care group as well, there were a lot of managers on there that had overstocked on some of their PPE, so they would go on to the group and say I've got 1000 masks in stock at the moment, this is the price, this is the certification to say that they are what they are. A lot of the stuff as well, through

Skills for Care, we were buying off other registered managers who had been able to get them in different regions. It was brilliant".

Providers were also complimented for filtering through COVID-19 related information and supporting individual homes to apply the guidance.

"We were up until god knows what time at night sorting stuff out and preparing, so the guidance would come through and we would say we have already done that. [Company] have been amazing I have to say – they have been brilliant. They have been amazing, and I do feel lucky to have been working for a big company that have got their stuff together really."

4.6.3.2 Support from health and care commissioners was helpful but had the potential to duplicate

Health and social care commissioners recognised at an early stage of the pandemic that providers would have different support needs. As the crisis unfolded, they identified that much of the demand for their support was from care homes and was clinical in nature.

"*In terms of who the queries were coming from, there were lots of local authority questions, but it was mostly from care homes and all questions were predominantly about infection, community healthcare changes and discharges. None of this had been expected and we hadn't scenario planned for this eventuality*."

Care homes reported that they were well supported by both the CCG and local authorities, often naming key individuals who made contact on a regular basis. The support ranged from training (including resilience) and sourcing PPE/equipment to general check-ins, which were very positively received.

"*We had a weekly Zoom conference with quite a lot of professionals on it including the CCG, and all of the other Care Homes in Worcestershire That was really helpful, even if it was just to hear that you were not the only one struggling. We had weekly phone calls from the brokerage team, I think they were doing it on behalf of the CCG at the time, just making sure that we were ok and if there is anything that we needed within the home… We had a lot of training provided for us from the CCG, they provided us with infection control, donning and doffing and we had resilience training as well.*"

Managers noted, however, that for homes that had a COVID-19 outbreak the numerous calls from health and social care agencies might be distracting and yield a negative response.

"*I think if I had been getting those calls when I was trying to deal with COVID in the home, I think I probably would have been a bit rude to some people, I don't know. It has been very easy for us to be very calm and collective in all of this and take a very proportionate response on it, but I am very aware that we have been quite lucky.*"

Commissioning leads saw partnership working enhanced through the combined support to care homes during the pandemic. They reported improved multiagency working, with senior staff

relationships across organisations becoming more collaborative and consultative. They also described how the system itself was now better understood by those who were more at the periphery of health and care delivery, such as local councillors.

"*I think it has had a positive impact that we've probably done things that would have taken loads of meetings and jumping through hoops and we have just had to do them and it has proved that you can do it if you absolutely need to, really speedy decision making and very much improved working relationships with social care colleagues as well because we all had to use the resource that we had got to the best effect really so that we could support these care homes and domiciliary care providers.*"

A lack of adequate resources, in public health especially, was highlighted as impeding the system response to care homes, with both health and social care having to compensate in different ways. Through joint-working, some duplication and even inappropriate work was identified in the support provided to care homes. Interviewees noted that in future pandemic waves they needed to be mindful of using the available resource effectively. Commissioners were hopeful that some of the learnings from the crisis would be embedded, particularly in relation to coordination and pooled resources.

"A positive of that is our local authority colleagues have worked really well with us to try and agree new pathways, and to cut out disputes because obviously it is about money isn't it? It is about who pays and whether somebody ends up funding their own care, so you are always going to get disputes, complaints, appeals when you've got a service that is about money but we have had to have some really sensible conversations and say look we haven't got time to be arguing about who pays, we have got to make some rapid decisions and we have got to trust each other, we are going to do that so that the right patients are in receipt of funding."

4.6.3.3 <u>New ways of working within MDTs increased care homes confidence in themselves</u>

Homes were mainly supported by primary care and in most cases the relationships they had with their existing GPs became stronger. The new ways of working with GPs, through the use of Zoom meetings and consultations, was a '*dramatic change*' but were welcomed for bringing efficiency. GPs were also credited for placing their trust in the ability of care homes' nursing staff to manage residents through the crisis. For some homes, the way of working with GPs had changed forever and for the better; for others (especially where nursing/clinical expertise was limited) more consideration by primary care of residents' needs was requested.

"[GP] is just brilliant, we have now put some really concrete changes in about our practice and the way we function with GPs, which we have never been able to do without COVID – there are some silver linings."

Care home managers reported being more involved in MDT meetings via the introduction of remote access. They felt they were trusted more and their equal footing with wider operational leads (for example specialist paramedics, physiotherapists, district nurses) in these settings was described to be 'revolutionary'. Within MDT discussions, care homes' nursing decisions could be constructively challenged, which they found helpful.

"*I suppose what it feels like not only from a practical point of view, yes I can access physio, I can talk about a patient quite readily, but actually it feels like they are finally listening to the work that we do rather than us being seen as the lowest denomination of well that is where old people go, where we warehouse them."*

In the new way of working, care home managers also reported being able to deal directly with other health care professionals without going through GPs, and how this had increased the perception of accountability and trust between professionals for the benefit of the resident.

"The trust element I think is a really big thing. That we trust each other as professionals and that communication level goes up and we have that respect and trust for each other, and that we are given accurate information."

4.6.3.4 Care homes had to address challenges from other parts of the system

Two of the four homes reported negative experiences with hospitals during the initial pandemic response. This centred around care homes '"*standing our ground*" and "*being a pain in the bum*" and insisting that care home residents/admissions have a test for COVID-19 on their discharge from hospital, as national guidelines stipulated.

"*We are all under the same level of pressure and maybe that is just the situation that we are in, but yes refusing COVID tests when we knew that the government were saying that they should be tested before they came out, not giving us some information, telling us that basically they knew better, and their policies and procedures should trump ours – well they don't……Every day we were having people from the respiratory ward basically saying that the patient is coming back and that we have no right to say no, and I thought well I have. We haven't got the PPE and you are not helping us with this."*

Commissioners acknowledged that given the ambiguity of national guidance at the time, there had been pressure on homes to accept patients discharged from hospitals.

"*I think some of them felt they were really put in a difficult position by that and it was difficult because we just had to keep reinforcing it, we were not making up local guidance, this was national guidance that we were working on... some of the care homes did accept patients and then sadly had really high numbers of deaths and really significant outbreaks and that was really hard to manage*."

Decisions made by care homes to safeguard their residents also created tensions with other healthcare professionals.

"The only issue we had was that we refused Physios coming in, so they reported us to safeguarding – that was probably the only issue. [GP] was amazing and she just cut across all of the complaints and just said yes, but let's not forget that [Care Home] is the only one out of those homes that you have just listed that remained Coronavirus free. Those people may have not had their Physio visit, but they didn't catch Coronavirus and die."

Staff in commissioning organisations who were supporting care homes became painfully aware of the emotional toll the pandemic and the uncertainties it had placed on the sector.

"*Care homes were phoning in saying they had no protective equipment, asking what to do when patients died of COVID. There were lots of difficult calls with care home staff sobbing in the background*."

It was clear to the care home managers that better communication between them and other healthcare providers was needed, with a shared understanding developed of the different pressures faced. It was suggested that maybe *"hospital staff could walk around care homes and care home managers could go and see what it is like for a hospital bed manager."*

4.6.3.5 <u>Information from national sources was overwhelming and came too late</u>

Care home managers described government support as 'masses of information' and multiple websites to access. More specific guidelines for care homes were deemed to have come too late, with homes and companies having already issued their own policies or, in the absence of this, staff 'muddling through' until relevant national guidelines became available.

"*So when COVID started, [company] produced their own pandemic policy in line with the government guidelines but as we all know, they changed daily. Most days there was a new piece of government legislation*."

For those supporting care homes, the guidance was felt to be too "*slow and too academic to support practical delivery*" and changing too rapidly.

"*We really got into the habit of saying things like "the guidance as of today says…" because we knew it would probably have changed overnight*."

Interviewees described the government's national response to health and social care needs in the crisis to be "*woefully inadequate*" especially with regards to PPE. There were also problems reported with accessing tests, with one care home having its tests recalled. This home suggested that if the tests for care home staff and residents had been available earlier and more consistently, outbreaks in care homes could have been avoided with the identification of asymptomatic individuals.

"*We have been doing the weekly testing of staff and monthly testing for residents but unfortunately, they have recalled all of the tests, so we are a bit stuck at the minute. It was a government recall on*

the tests which we were provided with to do our weekly tests, so not able to do this at the moment – we are awaiting a new delivery of tests right now.

There was some concern that new reforms would be introduced as a consequence of the pandemic, and that these would not be fit for purpose, further exacerbating health inequalities in vulnerable aspects of the system.

"*In terms of how the NHS and Social care move forward, they are talking about all of these big reform plans...I just hope there are people at the top who have worked in these environments and they understand how it works*."

4.7 Mental Health Services

Twelve interviews with Mental Health professionals working across a range of services including Child and Adolescent Mental Health Services (CAMHS), Learning Disabilities, Improving Access Psychological Therapies (IAPT), Perinatal Mental Health, were conducted in May-July 2020.

The key themes identified through the analytical process are discussed in the sub-sections below:

- The emergence of new mental health needs and deterioration of existing illnesses is expected to create additional demand on mental health services.
- Delivery of technology-facilitated patient-centred care in mental health services demonstrated more variation by service, professional and patient than elsewhere.
- Collegiality and wellbeing support had allowed staff to deliver services at the time of the first wave; concerns were voiced for maintaining staff morale for future waves.
- Multi-disciplinary mental health team working at system level was desired for the future. National clinical guidance can be supportive of this.

4.7.1 Need and preference in mental health services

4.7.1.1 <u>The demand for mental health services fell whilst old and new need rose</u>

Many mental health practitioners reported that as lockdown was enforced, the demand for mental health services fell. This decrease was perceived to be due to a combination of shielding advice or the rapid changes to service delivery and information regarding changes to access of NHS services that were not fully communicated. Interviewees worried about patients that were most in need and not accessing care; some were hopeful that those in need were accessing community-based third sector organisations due to fears of being in contact with health services. It was argued that more proactivity at the national level was required to encourage and reassure patients to return to their normal care.

"*So I think there is a lot of work to do on a national level of getting patients back into services, getting patients to acknowledge that their mental health and their physical health is really important, and to access help when the need to, and the pandemic shouldn't be a barrier to that.*

The expectation was that as health services resumed normal services, especially primary care referrals, the demand for mental health services would increase and much of this would be new activity related to the pandemic as people began to feel the strain of social isolation. Interviewees believed that a mental health "*crisis is looming"* and could lead to an onset of more severe mental health conditions which included: depression, anxiety, complex bereavement, Post-traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), trauma and behavioural challenges.

"*We were expecting this peak in demand which I'm more confident will come, because that's just human nature – it will come. But we just need to be prepared, and I'd like to think that some of what we've learnt and our preparation has already set us up for that.*"

On the other hand, some services, such as CAMHS, still described themselves to be operating as business as usual with regards to demand and maintaining the focus on meeting waiting time standards despite changing the mode of consultations.

"*We have to very up to date with the access and waiting time standards and even within the COVID-19 period we've not breached and even before that we've been really tight in making sure we follow that very carefully and get our patients seen as soon as possible.*"

4.7.1.2 Mental health service users experience of lockdown was more extreme

For some mental health services, it was reported that there was a great deal of understanding by service users for the changes taking place, with no complaints being received, and in fact reports of patients being thankful for the care that continued. However, in other services or different cohorts of patients, changes to the service provided was difficult to adjust to. For example, patients who had to adjust to a different healthcare professional over a virtual platform.

"Some of the young people have really struggled with a change of worker – the move into hubs has meant that some young people have had to continue their treatment with a different clinician than who they began treatment with. When this is done over the telephone with someone you don't know this caused some difficulties with some young people."

At the other extreme, deterioration of existing mental health illnesses was becoming evident with increased reports of self-harm and suicidal behaviours as a result of lockdown. For those admitted to hospitals, new social distancing rules, such as no communal activities, meals in rooms, and absence of visitors, led to further exacerbation of illness and poorer outcomes.

"Patients were disappointed and although some patients have been accepting of the situation, for others who already had issues with abandonment there have been some that have ended up on the wards, some have had to be detained and one or two are being considered for out of county placements. This is heart-breaking, if we weren't in lockdown it may have been a different outcome."

4.7.1.3 Remote consultations are not tenable for many mental health needs

For most mental health services, face-to-face consultations were stopped and video consultations were offered instead, unless need dedicated otherwise. For example, ante-natal mental health screening appointments were cancelled but women at high risk were referred directly to a full psychiatric assessment. The majority of patient consultations conducted virtually included psychotherapy, Cognitive Behavioural Therapy (CBT), IAPT and dementia support. However, some psychiatric appointments had to be postponed as they could not be conducted remotely, for example treatment for personality disorders.

As a result, there were mixed perspectives on the suitability of using video consultations in mental health services. For some, remote consultations naturally lent themselves to mental health as there was minimal need for hands-on care. They were also perceived to be more efficient, reducing the time needed for consultations, with good engagement from patients observed, alongside reductions in DNAs. Hence, some believed virtual appointments should be the default for the future.

However, for other mental health services such as inpatient, crisis and liaison care, practitioners described the numerous challenges with remote consultations. These included: establishing new relationships and developing trust with patients virtually; diagnosis without scanning and therapy, monitoring of physical health (for example for eating disorders); lack of suitable spaces in the home for some patients to hold a private conversation; and, patients who opted out of video calls making assessment difficult for mental health professionals.

"*A concern that the service could say is that the young person isn't engaging with the service, but it may be that they don't feel comfortable with engaging in that way.*"

For the time-being, interviewees described using their clinical judgement to assess the best option suitable for the individual patient within the limits of what was possible. For the future, they suggested adopting a "*tiered approach*" with phone, video and face-to-face support available, with consideration of both the patient and professional preferences.

"*So giving them the choice between WebEx and telephone calls, because we don't want to disengage them. Making sure that other agencies are aware we're open for business.*"

4.7.2 Rapid changes to mental health services

4.7.2.1 <u>Delivery of mental health services was reorganised to be safer and more efficient</u>

To prioritise the delivery of safe services for those most in need, mental health services had reconfigured and adopted a hub system, categorising care according to risk. Classification of hubs was as follows: Hub One - online or telephone assessments and arrangements of follow up appointments; Hub Two - ongoing treatment and frequent consultations via video or telephone; and, Hub Three: delivery of face-to-face urgent care. Hub Three also supported the other hubs to control for risks, adopt preventative measures and safety plans. Hub working meant that clinics had merged and there was more partnership working.

The rapid changes in mental health services as a response to the pandemic were received positively by mental health practitioners. Delivery of the changes had been efficient, and individuals recognised their own proactive roles within the collective service and organisational change, that had been achieved.

"*And that's in so many different areas, so many things have been so smooth, there's been a lot of more reduction in red tape and bureaucracy. And that's what we should see, that's exactly how it should be, that's how you get organisations to be far more responsive, rather than constantly being reactive*."

Most of the mental health staff interviewed had their own laptops, webcams and access to the appropriate software such as WebEx and Microsoft Teams. Of those that mentioned that they did not have a work mobile, they described that it affected both client contact and work/life balance.

"I haven't got a work mobile phone which means I need to dial 141 before client's number so that it disguises the mobile number. Also, staff will call on a day off and that makes it difficult when it is your personal mobile."

The availability of a digital platform was reported to have facilitated team working: in developing relationships; reducing travel time; and improving communication. Most staff were reported to have accepted it as a mode of working, and were seeing the benefits of working from home. There was recognition from service leads that if home working was to continue, then more office equipment was necessary.

"*Because this is going to go on longer term, do staff need additional things at home. So if they're working at home they might need an office chair, Do they need extra screens, do they need a mouse, do they need keyboards? Looking at more DSE assessments, so the desktop working assessments, especially for staff who are self-isolating.*"

4.7.2.2 <u>Mental health professionals supported one another to cope with the crisis</u>

The new ways of working affected staff in numerous ways. Whilst many moved to homeworking, others were redeployed to cover for staff that were shielding. For some services and Hub Three working this placed some staff under more pressure than others (including in their personal risk for infection). Despite this, mental health teams were described to be resilient, "*incredibly committed*" and flexible.

"There's often this dilemma isn't there, between wanting to do everything you possibly can to help people, versus having to balance that against your own priorities, your own work/life balance, or you own needs to protect yourself or your family in terms of the coronavirus."

As the pandemic took hold and pressures on the mental health services continued to increase and was expected to rise further still mental health leads voiced their concerns around burn out and the toll on their staff. They acknowledged that the recognition from the public and the value that people put on NHS staff had raised staff morale. The availability of a 24/7 mental health staff helpline was also deemed to be supportive. Nonetheless there were concerns:

"There's certainly a sense that everybody's very aware of their own mental health. I mean to be fair, you know, the staff seem to be struggling more than the patients at the moment."

To combat the individual challenges, teams were described as becoming more cohesive, taking on a 'trench warfare mentality' in order to respond to the pandemic together. Numerous examples of promoting team spirit were described, including: a rota between home working and office working so that staff who wished to could meet and work with colleagues in a safe way; delivery of 'goodies'

to colleague's homes; yoga activities, quizzes and informal catch-up sessions to maintain staff morale. These activities were perceived to be important in preparing for the second wave.

"I've worked hard. But that patch of two or three months ago was bloody hard. So I think at some point, I'd like to think we'd get to a point of stability and we can just ease off the throttle a bit and slow down a bit and just hopefully give people a chance to recover a bit".

4.7.3 System working to deliver mental health services

4.7.3.1 <u>There was support for strengthening multidisciplinary team working</u>

Majority of mental health practitioner interviewees had prior experience of working within multidisciplinary teams, including across organisational boundaries. In most cases, this has continued as previously but through remote meetings instead.

"As you can imagine, sometimes it's a bit difficult to separate the social care needs and the healthcare because they impact on each other so much, especially with our guys, so we've kept the relationship, we still have joint referral meetings and we are still doing them online as well with our social care colleagues."

Virtual working across organisations had improved partnership working both within mental health services, locally and nationally, but also with other professionals including GPs. There was a strong desire to maintain this wider multi-disciplinary working in the future.

"I've instigated a weekly meeting for the managers, and that sharing of experience is absolutely enormous, and finding out what other people are doing, what works, what doesn't work. And before we wouldn't have had that because everybody was just – and still are – they're even more busy than ever.".

4.7.3.2 <u>Mental health professionals were sufficiently supported locally and nationally.</u>

Interviewees were complimentary of national teams and appreciated that mental health was a priority. Staff received guidance from professional bodies such as the Royal College of Psychiatry and were able to cascade information to local teams.

"The national teams have been amazing, I have to say, they've been on a regional level have been fantastic. So from the national team to NHSE, CCQI (College Centre for Quality Improvement), they've all been great. And other areas have been really supportive too. So there's much more of an openness and sharing of ideas and being collaborative, and I'm hoping that will continue.".

Advice and provision of PPE was sufficient for most mental health staff, but a few mentioned that there were 'mixed messages' around the guidance which only served to confuse. On the other hand, interviewees were in agreement that they were enjoying the local autonomy they were given to make decisions.

"I'm trying to say is, on the one hand that there's been an atmosphere of just get on and do, make the changes you need to make, you're committed to do them you know, implement rapid change and just get on with it. And that's been quite refreshing, and we haven't needed support doing that."

4.8 Cancer Services

Interviews with eight cancer service leads (range of specialities) across two Trusts took place in June-Aug 2020.

The key themes identified through the analytical process are discussed in the sub-sections below:

- Patients were reported to be positive about cancer services that they could access more rapidly, for example through virtual appointments especially when they were rurally based.
- Staff working in cancer services welcomed a more agile way of working, with services responding to need more flexibly, including in their use of technology to facilitate both patient care and ways of working.
- Cancer service leads were empowered and took responsibility for decision making for their service, unhindered by historical bureaucratic and siloed processes.
- There was widespread concern both about the poorer outcomes of later diagnoses and treatment for patients; and the emotional impact of this on the wellbeing of staff.

4.8.1 Potential widening of inequities in access and treatment for cancer patients

4.8.1.1 Patient access to cancer services expanded as a result of the pandemic

There was a broad consensus amongst cancer service leads that there were opportunities, through the pandemic, to provide care differently to cancer patients. This was especially the case for patients living in rural locations. Remote consultations were seen to bring advantages for: pre-chemotherapy appointments; discussion of scan results; two-week referral appointments; involvement of family members in treatment plans; and, some follow-up discussions. Service leads described the need for additional preparation prior to remote consultations, for example in emailing out information beforehand, to make them effective in providing care.

"*In some respects, moving to a virtual platform has been welcomed, especially in a rural county like [region]. It has demonstrated to us that people should not have to travel to have those sorts of inputs. I think that is a real plus.*"

There were mixed views as to whether appointment times were shorter with remote appointments. In some routine or follow up appointments, such as when patients were enrolled in clinical trials, consultations were perceived to be more efficient via telephone. Whilst in other instances, clinicians reported that consultations were longer as patients disclosed more information on their condition, symptoms, and side effects on the phone. Other challenges for clinicians in the virtual delivery of cancer care were outlined to include: breaking bad news on the phone; maintaining privacy from household members; demonstrating exercise advice and the inability to physically examine patients. Despite this, when patients were offered the choice most opted for remote consultations, leading service leads to conclude that there is a role for alternatives in future cancer service delivery.

"We utilise our time in different ways and same with using telephone clinics – a lot of that will stay after COVID so we have recently agreed that most follow ups will be via telephone call with an anticipated 80/20 split. 20 percent face-to-face active surveillance will move back to face-to-face as will need to examine patients."

Where patient anxiety led to a reluctance to attend clinically necessitated face-to-face consultation, they were phoned by clinicians to encourage them to attend.

"*Therefore, we have been able to do a lot of the work to a satisfactory level within governance and clinical parameters to reassure patients. For new patients, we have been able to reassure them and offer them appropriate advice and follow-up, as necessary*."

In addition to remote consultations, cancer services also reconfigured their service offer to improve safety and provide flexibility, such as using the car park and a booking system to handover routine drugs to patients who were enrolled in cancer clinical trials, and out-of-hours phlebotomy.

"*At each of the three hospitals in the Trust we set up a service that the patients were allocated a time that suits them and they drive up to a space at the hospital and the nurse takes drugs out to them in the car park. It works really well and actually I think the problem will be getting patients out of that system when this is over because they've really liked it*"

Service leads involved in cancer trials were concerned that some cancer patients, in the absence of receiving full physical assessments in a timely way, had missed the opportunity to enrol and as a result to access a different/novel treatment.

4.8.1.2 Clinical decision- making prioritised cancer care by need

There were also changes made to the processes of clinical assessments for patients to allow for the prioritisation of care for those that were in the most urgent need. This was done through a combination of standard cancer risk-assessments, for example Brock Scoring for lung cancer.

"These decisions were based on Cancer Alliance guidance on triaging into categories 1-6. Treatments which were not curative intent or did not have likelihood of curative intent were delayed or deferred."

In part, some of this prioritisation was possible due the decreased number of referrals. Clinicians reported that many patients were relieved that doctors were making the final decision for their care; as patients themselves did not know what to do in the context of their cancer treatment and their COVID-19 safety. However, whilst this clinical prioritisation of care needs made patients 'feel less guilty' it could be more difficult to accept for wider family members.

"A lot of patients fit into two groups: one worried about cancer and other worried about COVID. Both have levels of anxiety but for different reasons. Patients base their treatment decisions on COVID. Most common feedback we get is thank you for being there."

4.8.2 Changed processes were efficient for service delivery

4.8.2.1 Ways of working changed due to reduced demand and safety concerns

For the majority of patients, cancer services including diagnostics, referral to treatment, and treatment continued to run as normal albeit with a lower demand. The throughput for chemotherapy and radiotherapy also reduced and the independent sector was used to support service delivery (for example endoscopies, biopsies, surgery).

"So traditionally we would have run a separate telephone clinic, but this got suspended and now all follow-up clinics are by telephone, amalgamated the list into our existing capacity. The two week wait clinics declined in frequency as referrals from GPs reduced, so just one day a week and now recently (within last month) twice a week. Pre-COVID the clinics ran three times a week."

More notably, the procedures, administration and logistics have been changed to improve safety for patients and staff alike. For example, there were temperature checks and swabs taken at the entrance of buildings, a pager system to call patients from cars and enforced isolation prior to surgery. For staff there was an office rota, they were no longer able to rotate through clinical rooms and two metre safe distances were marked out.

"*Quite strange new ways of working, not shaking peoples' hand when they walk into a room and being quite mindful of that*".

Where home working was possible, such as for non-clinical staff and MDT members, positive efficiencies gained through technology especially in the ability to work and hold meetings virtually were described.

"There are huge efficiency gains. Before COVID, we would not have thought of having a virtual meeting. I do not know anybody who has not welcomed it. We have been able to move things forward quicker."

The changes made to staffing of cancer teams varied; most were without large changes in staff or skill mix (with nurses and those involved more substantially in clinical trials more affected by redeployment). As a result, the management of known patients virtually only required training to use specialist software for consultations (Visconn).

"*The only training required was need for Visconn which was provided to all staff. Personal laptops were issued from the Trust – if no face-to-face clinics were needed, staff could work from home. We didn't identify any further training needs. There is no change in staff morale as we are working effectively and as a small team, people look after each other.*"

In particular, the opportunity for clinicians to deliver clinical care, unburdened with fewer administrative tasks as a result of the new processes was perceived as having diminished the fear of change for staff. In general, it was reported that staff would like to keep those changes that they saw as positive, although investment would be required.

"When it came to mobilising teams and making things happen quickly, we proved that we could do that. We do need funding to sustain that."

There were numerous challenges described in delivering cancer care, most notable of these were those for working as MDTs. With staff redeployed to other services, not all teams were able to ensure representation in MDT meetings. Whilst cancer MDTs were perceived to be working better than pre-pandemic, due to discussion of fewer patients, there were various difficulties reported during the early stages of the pandemic relating to: 'ad hoc' radiology/diagnostic support; reduced surgery options; and video-conferencing challenges, including in sharing good quality CT images in virtual meetings. Later discussions revealed that many of the technology challenges were addressed and virtual coordination and planning improved. Face-to-face teams were reinstated, facilitated by a large meeting room made available to cancer teams that provided sufficient space for social distancing.

4.8.2.2 <u>Increased demand for cancer services was expected to challenge the capacity to deliver care</u>

Interviewees working within cancer services were concerned about the "enormous scale of future work" placed on their service due to the pandemic, especially as they were anticipating further burden through a second wave of the virus.

"*The problem we have is not knowing if we are going to have a second spike. We cannot long term plan which is hard. We want to get things moving again but we have got to be mindful that at any point we might lose the extra nurses that have been given to us by the network and staff can be redeployed. We are working week to week at the moment*."

Their concerns were primarily around the delays to treatment and missed diagnosis of cancer during lockdown and beyond, the impact that this would have on demand at a later stage and that this was likely to impact some cancer services more than others.

"I think the demand for cancer services will increase for at least the next 6-12 months. We will feel that as clinicians as we see more advanced cases or missed cases coming through, but that cumulative effect will be felt more by the wider oncology community and the oncologists delivering radiotherapy and chemotherapy."

With the increased in demand, there was an expectation that some services would need to move to seven day working. There were anxieties that the extra capacity currently available through the independent sector would end and performance targets would be enforced, resulting in impacts on the quality of care and an overworked workforce.

"Quality and quantity of life for patients will be affected and surgeons inundated with number of referrals and amount of work from patients will significantly increase. Concerns of bottle neck of patients and surgical workforce will be exhausted, working at weekends, extra hours to accommodate the big explosions of cases in the future. Government targets will be enforced with no increase in capacity".

Despite the challenges that lay ahead there was positivity that many of the service changes made during the pandemic brought benefits that could be sustained, had provided staff the opportunity to test service improvements and in doing so to identify efficient pathways for patients, for example triage of GP referrals for non-site specific symptoms.

A longer-term concern of interviewees was the mental health and wellbeing need of the clinical workforce when the cancer prognosis of patients was expected to be worse as a result of COVID. This was particularly concerning for less experienced staff who had had to have difficult conversations with patients whilst working from home, in the absence of wider team support.

"After a couple of months I became concerned for their mental health and wellbeing due to the nature of their calls. During that time, they were talking to people who have got cancer, with concerns about COVID on top of that. We made the decision, before most teams, to bring them back in. If they had been more seasoned healthcare professionals with many years under their belts, I may have felt differently about that. It made a difference."

There was also a more general concern around how clinicians would cope in the future when faced with the reality of poor outcomes, and that early assessment and proactive support was necessary.

"I'm concerned that staff may find it difficult when looking back at the COVID response within cancer services and think 'if only we had treated that patient'. Therefore, analysis of what could have been done differently or better needs to be managed carefully."

4.8.3 System working identified to be paramount for the future of cancer services

As with other services, cancer leads described being empowered through their newly acquired ability to make decisions for their services in the absence of bureaucratic practices:

"Clinicians have felt empowered within their limited resource to make changes. It drove efficiency and improved job satisfaction. As a clinical leader within the NHS, I felt empowered, engaged, and responsible. I felt responsible for the governance without committees putting lots of tick boxes and check lists in place. How to maintain that over time is a big challenge".

Staff welcome the removal of barriers to change, the ability to rapidly implement new ways of working to system-wide cancer services delivery. A new-found respect for research was also

described, as many clinicians became involved in COVID-19 research and sought out the expertise of cancer specialists with experience of running clinical trials.

"I have found huge benefits that I have capitalised on because of COVID. I have seen a slashing through and cutting down of all the usual red tape/ sign-off. It has been a very welcome change and I would love if we can learn from this as a system."

Cancer service leads acknowledged that cancer pathways across primary, acute and tertiary would need to be reviewed through a system approach to address the issues brought about by the pandemic. For example, the reduced presentation of cancer symptoms in primary care and the possible increase in presentation elsewhere such as out of hours or A&E was seen as requiring a focused discussion with primary care to reinstate usual but improved routes of referral. Similarly, there was concern that in the absence of tertiary cancer services in H&W, local patients with complex cancer needs would be disadvantaged. Clinicians suggested that system leaders should lead discussion with peers in the region to ensure equity in access for tertiary cancer care for local patients.

There were different perspectives around the national support. Whilst access to PPE had been made available as required, interviewees described how there had been confusion about the national guidance in appropriate use for clinicians. Interviewees acknowledged the plethora of national advice and guidance from various cancer professional bodies, and recognised that the majority of the guidance used in practice was from the regional Cancer Alliance.

4.9 System

Five interviews with system leaders (identified on the basis of their GOLD/Level 4 National Incident Response responsibilities[8]) were undertaken by the Strategy Unit in July - August. The analytical process identified key themes that are expanded in the sub-sections below:

- The peak of pandemic demand was lower in Herefordshire and Worcestershire than predicted. However, care homes were placed under most pressure as activity was shifted from hospitals.
- There a system-wide culture change modelled by the system leaders. The clinical workforce especially was empowered to work collaboratively.
- System leaders were well supported by the command and control mechanism established for the pandemic response, as well as national and regional peers.

4.9.1 Balancing population need with demand

4.9.1.1 Demand for pandemic-related health services was lower than expected

System leaders reported that the peak of the first wave of the pandemic was lower in Herefordshire and Worcestershire than predicted by modelling exercises. They perceived this to be due to their being "*behind the London curve*" in community transmission when the national lockdown was instated. In addition, the rurality of some areas in the system geography led to lower transmission rates. At the time of the interviews, system leaders were focusing on preventing further outbreaks, with confidence in national infrastructure and local experience.

"*But look, from my mind this is the way it was always going to go and we just have to focus on managing the outbreaks as well as we can do, making use of the national infrastructure around things like testing and tracing and making sure – probably most importantly for us – that we are learning as we're going along and we're focused on prevention.*"

Whilst the direct burden of the first wave was lower than expected, including from the long-term effects ('long COVID'[9]), the indirect impact of COVID-19 through the lockdown was expected to be high. System leaders identified that the greatest need would be for people with known mental illnesses, homeless individuals and those disadvantaged by multiple vulnerabilities.

[8] National Incidence Response Plan. NHS England 2017. England https://www.england.nhs.uk/wp-content/uploads/2017/07/NHS-england-incident-response-plan-v3-0.pdf

[9] Nabavi, N Long COVID: How to define it and how to manage it BMJ 2020

"*Early on there wasn't really the understanding at which particular parts of the community, ethnic groups or , economic groups were going to be particularly affected. We saw initially quite a fair number of more elderly patients coming in, and then of course as the understanding of the way the virus is working became clearer, it was then , OK right, obesity groups were at particular risk, lung, cardiac and colon disease were particularly at risk*." (SL5)

4.9.1.2 Demand shifted to different parts of the system

System leaders that were interviewed described an overall fall in healthcare activity. However, they also identified how demand had shifted from one sector to another. For example, with the cancellation of outpatient clinics in secondary care, patients accessed primary care instead and, as GPs stopped home visits, community nurses saw additional patients in their own home.

"*It was a bit of a sort of cascade, wasn't it?....primary care were feeling that there was a workload that had come from acute to them, because outpatients weren't doing a lot of things, and then workload came from primary care to community nursing, because primary care weren't going out and were asking community nursing teams to go out.*"

At the time of the interviews, demand was described to be returning to normal in some health services, particularly urgent care. For other services, such as elective, cancer and primary care, demand from patients was still reported to be lower than expected for the time of year. There was some concern that with the system's attention focused on urgent care, there would be insufficient time to tackle backlogs building elsewhere such as elective care and diagnostics, within the waves of the pandemic.

"*It's all been urgent care and all the capacity and efforts have been targeting that, and very urgent elective care. I'm cautious and a bit concerned and there's a huge risk about our ability to make much inroads into the elective care backlog. I think that's going to be really difficult, depending on how outbreaks develop and how further peaks come back to us*."

4.9.1.3 Care homes bore the brunt of system demand

Leaders acknowledged the burden placed by the system on care homes during the crisis when they were already severely challenged due to public-sector austerity and lack of national oversight of the sector. The additional pressures placed on care homes during the pandemic as a result of: prioritisation of acute services; rapid discharge of patients from hospitals; the volume of information; the changing safety guidance; lack of PPE and adequate testing – created a perfect storm.

"*The focus on acute capacity in the first few weeks and actually it's a fair comment to say we desperately tried to discharge people from hospital into care homes, we had no ability to test them for COVID...we undoubtedly put care homes operationally under pressure. The availability of PPE, you know, that was initially targeted at the front line, and by front line I mean A&E and critical care, the small supply that*

there was. It took a while to get proper supply chains into care homes and I think that's regrettable really isn't it."

The system view was that the care homes crisis was managed better locally than many places nationally, because of additional system-wide support they were able to provide such as an incident helpline, access to testing and swabbing as relevant, and deployment of community nursing where requested.

"Nursing homes were approaching some of the community staff and saying, you know, 'we haven't got any PPE and can you help and we haven't got any staff', all the staff were off sick, 'can you help'...we really rapidly put in place an intervention team of mainly sort of senior experienced nurses to go into initially those nursing homes that had got positive patients....we'd gone into half a dozen nursing homes over the course of one weekend and provided support, advice, training, equipment where we needed to."

System leads described that they had learnt from the national care homes experience and were developing an integrated offer of support across health and care services. However, within this, there was recognition of the range of expertise available and the need for appropriately tailored involvement.

"In COVID we've almost started to take quite a paternalistic view of care homes and started to almost say we've got to do this to you. And some of the care home managers I've talked to – albeit they're in the bigger chains of care homes, not independent ones – you know, I think they felt a bit affronted actually that they've got a huge amount of skill and actually they could do some – you know, they were happy to do some of this themselves."

4.9.2 Partnership working in the pandemic resulted in a culture change

4.9.2.1 Leaders modelled collaborative working

The local response to the pandemic was described to be led by the system partners, that is the STP who were developing themselves into an ICS. and consisting of providers from primary care, social care, public health and commissioners. Interviewees acknowledged that their system was not a complex one with coterminous boundaries with local authorities and provider organisations. The primary care involvement in the STP had been strengthened and the involvement of Clinical Directors from NHSE&I in GOLD was also appreciated.

"I think we were lucky in that as an STP from the very beginning we involved primary care very heavily and they were involved in all of the strategic decision-making forums right from the beginning.....We're not complex as an STP, like some STPs, you know, there aren't a huge number of players, are there, in the system. So I think quite quickly, we slipped into almost a team that were working through the ICS work."

System leaders were pleasantly surprised at the extent to which their own relationships had improved as a consequence of working closely together over an intense period of time. Their own culture was described to have 'changed completely' and there was a strong desire to continue this way of working collaboratively, which included regular action-oriented meetings.

"*One of the things I do think is apparent is people do seem to own each other's problems much more than they did before this started. So we have a GOLD call with all Chief Execs and when somebody says 'I'm really struggling with this', what would have happened twelve months ago is everyone then stays silent and, you know, 'well what are you going to do about it then?'. What we seem to have had is this culture of 'right, OK, well how can I help you?' and 'have you thought about this?' and 'can I give you some suggestions?' and 'can we support you*?"

This changed culture at the top was reported to have cascaded down, through STP-wide executive-led cross-organisational working groups tasked with pandemic-related activities. In turn, provider organisations and their staff were credited with 'rolling up their sleeves' to work across organisational boundaries.

"*Putting GOLD in place with the Chief Execs in place getting together on a daily basis, giving that, you know, that command and control feel to the system, and showing that they were working together, I think really helped the rest of the system. It sort of set the tone really for the rest of the system. And then having the plan, the joined-up plan of what we were going to do, in response to the demand and capacity modelling, that really helped us as well*."

System leaders described how structures and levels of involvement changed in their respective organisations in order to deliver an efficient and coordinated response; they took pride in their involvement and being part of an organisation and system that had performed well.

"*And I'm very proud to have been involved, and to be leading our organisation and being a system leader that's done such good work*."

Leaders acknowledged that their system had previously found a true system approach challenging, but there was growing confidence that the pandemic had 'galvanised' the beginning of a change, wherein system working felt 'more natural'.

"*I think what COVID did was really pull people together with a collective spirit of we have one issue here and we're all working together and we've got to solve it together. So I think it really strengthened relationships in the locality actually and I think it really made people work much more as a system than we had been before. So we said we were a system before, but we were still probably a collection of parts*."

System leaders were keen to hold on to the close partnership working developed and identified aspects of involvement that needed to be strengthened. This included improved use of the independent sector to provide additional capacity and a more defined role of community pharmacy

in the system's urgent care response. There was some confidence that the changed mindsets of the public, that is more appreciation of the NHS and appropriate use of it, combined with a more coordinated and financially incentivised way of system working could result in a sustained improvement for managing the health and care needs of the population.

"*There's no doubt we've taken it further, whether that needs some legislative change in the longer term to bring health and social care budgets together, you know, it'll lead to some changes around the long term funding for social care, so that would be great to see long term funding with social care, which means that you could genuinely bring budgets together in a way that is still slightly clunky*."

4.9.2.2 Clinical ownership was enabled through proactive involvement

Clinicians were reported to be at the forefront of the system's response. For instance, forums were described for joint clinical decision-making to manage the restoration process. One such forum was an Ethics Committee, consisting of PCN Clinical Directors, a Medical Director, Nursing Director and Consultants. The original task of the Committee had been to manage pandemic-related clinical decision-making and clinical prioritisation on behalf of the system, but they also took on additional tasks as they emerged, for example in the local response to risk-assessment for the Black and Minority Ethnic workforce. Clinical forums such as these were described to be invaluable.

"*In the end, it's your clinical teams working closely together that make a difference to the patients. It's not the mandarins putting a government structure in place.*"

Credit was given to provider organisations for being proactive in seeking front-line engagement, for example one trust was leading a virtual event, engaging GPs, consultants, social workers to explain the system, the Board operation and people to contact. System leaders recognised that these high levels of clinical engagement, involvement and empowerment within the system needed to be maintained; they described how more effective clinical ownership conversations were just beginning and the importance of these for an effective system approach.

"*We want to maintain the agility, the clinical leadership, the clinical engagement and the being able to work across boundaries in the way that we have and we want to retain all of that and so we've set ourselves a couple of relatively agile committees to be able to deliver that as part of system working*"

The value of individual GP participation and leadership in the system's response viewed as also highlighted as important:

"*So we've had system leadership forums before, the primary care voice has been quiet or non-existent. I think what I've seen through COVID is confident GPs stepping up and being part of the system….. How refreshing it's been to be able to talk to people from primary care with a mandate who can go away and make things happen in primary care*."

4.9.3 System leaders coordinated the local response

4.9.3.1 <u>The local response was supported by national incidence response measures</u>

Interviewees reported that the planning for the local response to COVID-19 was partly driven by the learning of their clinicians from the events unfolding internationally and as community transmission escalated in London.

"*And I think from the clinician's perspective, they were obviously in contact with some of their colleagues in London, and one or two of them had colleagues in Italy, who – and they were getting kind of warning signs in February that there was going to be a big issue from a critical care perspective. So [....], who's responsible for critical care was already starting to get anxious towards the middle, third week of February. I remember he came and knocked on my door and was anxious*."

At the earliest stages of the outbreak, system leaders discussed the need to implement the system-wide flu pandemic plan, before national guidance arrived. However, as they came to delivering it, they found the plan to be insufficient in detail and as a result not useful.

"*I think it's fair to say, with the benefit of hindsight, that our pandemic plan probably wasn't detailed enough, because we'd never experienced it….I mean, who knew before COVID that we would be asked to completely close down the majority of our services! Or change the way we did them like in a week or two?*" (SL1)

System leaders were in agreement that the Level 4 Incidence Response introduced by NHS England to coordinate local responses via a national Command and Control mechanism was appropriate, 'perfectly reasonable' and helpful in the circumstances. Within this Level 4 response, it was estimated that 70% of the system's response was nationally 'dictated', focused on where to release capacity for COVID-19. 30% of the response was then locally 'interpreted', for example where to redeploy the workforce.

"So in the beginning, it felt a bit more exposed, if that's the right word, because it felt like we were trying to work it out. Every trust was trying to work it out themselves. I think once the national command and control structure started to really kick in, I think it felt much more boundaried [sic] and much safer because everybody clearly knew and there was national decisions being made or local decisions being made that were consistent."

At the time of the interviews, system leaders were observing some inefficient processes and duplication creeping back in, especially with regards to assurance and governance. Whilst some of it was perceived to be necessary, interviewees were keen that what returned was proportionate to what was required.

"*So how we design that around that as an operational principle we're working through at the moment, but not duplicating anything is key. I was talking to my [....] today, he said 'I used to talk about Urgent*

Care in six different places for assurance, you know, I need to do it once'. And we need to maintain that."

Similarly, system leads acknowledged that many of the changes that had been introduced during the pandemic would usually be subject to public consultation. There was a worry that changes deemed innovative and welcomed by staff could be paused, delayed or reversed through consultations.

"*My biggest concern is that we won't be able to keep some of the innovations because of, you know, formal consultation makes that difficult or takes us backwards and, you know, I really just want to make sure all the good stuff that's happened and all the learning can go forward*."

4.9.3.2 <u>The system response was delivered through a committed workforce</u>

Leaders spoke with pride about their staff who 'embraced' and got 'stuck-in' to deliver the health and care response in whichever way they were asked to do. They acknowledged that front-line staff had compromised their own safety to protect others.

"*They're heroes aren't they all of them, I think. People that carried on working, particularly in front line service delivery, they were the ones that affected the mindset changes around working together, you know, the bravery that people showed putting themselves personally at risk. Maybe not always with the right levels of PPE, let's be honest, particularly in the early days. PPE was in short supply and we weren't able to provide people with what we would have wanted to provide people with. So first of all I think the front line staff deserve huge credit*."

Examples were provided of staff working innovatively, for example one Trust had repurposed testing equipment to enhance their capacity to rapidly test for COVID-19 in their own patients and staff as well as for other providers. Another example was provided of respiratory equipment being modified to make their use safer in nursing homes.

"*Our respiratory team actually designed some new kit and they modified a load of kit and, again, they provided that support into the nursing home, so they'd got safe equipment to use for those patients who couldn't do that with CPAP. If they'd got COVID that provides a huge viral load to staff and other patients and would have been really dangerous*."

The willingness of staff to work differently, be it working from home, working virtually, taking on new roles or working in new collaborations was said to have brought about '*a whole different relationship*'.

"*The workforce I think, they responded extremely well. And we didn't have some of the historical issues we would have had, if we'd have tried to do this outside of a national pandemic really*."

An operational challenge that system leaders described having to address very early on was the loss of staff, either due to shielding or COVID-19 symptoms/self-isolation. The self-isolating directive was said to have caught organisations off-guard; had it not been for the drop in demand, decreased staffing levels would have been problematic.

"*When the isolation rules first came in as well, we suddenly lost a lot of staff and I think the pandemic plans always say about what would you do if you were missing a lot of staff, but I think the reality of suddenly finding your 20% of staff down was still quite a shock in terms of running services. And it was only, because in a way that COVID wasn't as severe in our patch as quickly as other places, that we had time to close some services down to allow that to happen, make sure we got safe staffing*."

At the time of the interviews, leaders described that with the change in national policy for return to work, their organisations were putting into place risk assessments, balancing individual risks for physical health with wellbeing concerns. There was concern that whilst health and care professionals were still motivated and enthusiastic, there was a high level of exhaustion in the workforce, with many staff having taken no annual leave during the first wave of the pandemic.

4.9.4 National communication required national ownership

4.9.4.1 *The government's public communications during the crisis caused local operational challenges*

System leaders described government communications to be rapid in frequency and inappropriately timed for local interpretation. Operational problems were created by new government announcements late in the evenings, including on Fridays, leaving staff working over the weekend anxious around which policies or guidance to follow.

"We did try as chief execs to influence the fact that the national announcements at five o'clock in the afternoon on a Friday wasn't particularly helpful for a provider that worked over the weekend….In the early days that was quite a problem, because we probably spent a whole heap more time than was necessary trying to work out what on earth the guidance was, pre guessing what it might say, putting something in place knowing on Monday when the guidance actually came we'd have to change it again."

System leaders' views of the Department of Health's handling of the crisis ranged from frustration ("*no comment*") to "*it could have been a lot worse and they did very well*" with recommendations provided of what specifically needed improvement. This included more ownership at a national level of the communication of difficult messages regardless of the politically sensitivities, for example around being turned away from A&E or the need for less hospital beds (including outside of COVID-19).

"It's a bit bonkers, isn't it, because the public are sensible and actually with the right information will adjust their behaviour, but you want people to do one thing but you're trying to subtly not tell them – I think sometimes there's a reluctance to say publicly we need less hospital beds or whatever! And that actually then we're all left taking the flak locally. So I think there's something around communication, public information and the synchronisation of that that I think would be really, really helpful moving forward."

Others argued that rather than scoring political points, in crisis situations politicians should be providing a framework for enabling people who '*know what they're doing, to do the things that they know that need to be done*'.

There was also some criticism of the national actions that had been mandate, especially in the development and coordination of testing facilities.

"*I think the things that we did locally worked better than those things that were coordinated nationally, and I'll give you one example. The national coordination of reagents for pathology labs, and the development of Lighthouse Labs was a failure. What would have been better would have been to ask each of the laboratories to increase their capacity by 10% or 15%, give us the reagents, let us get on with it. And I think that would have been more effective.*"

Other national directives, such as for discharge and CHC funding, were more welcome. Leaders described how these had expedited changes that had previously been 'seen as optional' and stalled due to lack of system agreement.

"I mean it was something we'd already been trying to do anyway, but it was nationally mandated so you know, improving, getting people out of hospital as soon as they've recovered from their acute episode, and not keeping particularly elderly people in hospital for too long, I think has been fantastic. We've seen a huge change in how that's worked. So I think from a national perspective through to a very hands on the ground perspective, that has been a huge success."

4.9.4.2 <u>Local leads were supported by national peers and digital communication</u>

System leaders interviewed were unanimous in their view that the communication from professional bodies and their national and regional peers had been good, if somewhat overwhelming at first until the rhythm of managing the information was established.

"*To give credit to regional and national colleagues, they quickly developed good communications networks through using Microsoft Teams etc that gave us all a clear mandate a clear remit for what was expected and what was required*"

In particular, the ability to interact with peers, using WhatsApp and Microsoft Teams, across the country was helpful, especially at the start of the pandemic when national guidance was unavailable or difficult to interpret for the local context

"I think just having that peer test and kind of 'we're thinking of doing this' or things like the two metre rule when it came out, you know, 'does this apply to inpatient beds, have beds got to be two metres apart or not' – nobody knew, there was no guidance, so it was flying round WhatsApp 'what are you doing, what are we doing, we'll all do that then'!"

System leaders suggested that "*the NHS had learnt an enormous amount*" from the response to the pandemic including in delivering parity of esteem for mental health services, given future need was likely to be high. They also mentioned the need to focus on inequalities and placed-based care for integrated care delivery. More locally, they requested more autonomy and empowerment to act as true leaders of their system.

"Empower us, trust us, support us. We've learnt a lot, we've come a long way on this journey as well. What we need is a bit more autonomy and empowerment I think from the regulators, particularly in this system and the level of intervention we've had previously, I think we should have learnt some more autonomy through what's happened in the last three months."

5. Conclusions

This section provides a summary of our findings and the recommendations that emerge.

5.1 Summary

This qualitative evaluation, encompassing the perspectives of 7 patients and 68 professionals in Herefordshire and Worcestershire, provides an in-depth understanding of the health and care system's response to a pandemic which, at the time of writing, appears to be entering its second wave. The findings therefore provide a timely prompt for the system to put the lessons already learnt into action. In addition to learning for future waves of the pandemic, there are also lessons for a new business as usual that emerges for the system.

The peak of the pandemic, and therefore of the associated health and care services demand was lower than expected in Herefordshire and Worcestershire. Patient accounts confirmed what professionals suspected: they did not want to be a burden on the healthcare system, and they worried about getting infected in healthcare settings.

The response to COVID-19 was initially informed by local pandemic plans with additional strategic and clinical input; but the plans, developed for flu, quickly proved insufficient for the unprecedented crisis. National command and control as part of the Level 4 incidence response replaced these plans and provided the system with the necessary framework for strategic-decision making within the local context.

Individual services rapidly, proactively and characterised by a strong team spirit reorganised their services, took on new task and ways of working based on their assessment of urgency of patient need and ability to deliver safe care. Front-line professionals were supported by guidance from professional bodies and local leads who could interpret and filter from the vast range of information sources. The public on the other hand were very confused by national communication, particularly around shielding. They relied on their own ability, or those of their personal networks to access and interpret the information that was relevant to them. The lack of national/government support was the basis of much frustration, with the poor access to adequate testing and PPE being key to this.

Staff groups across the system responded as one workforce to meet the healthcare demands of the COVID-19 pandemic. In doing so the system unwittingly put undue pressure on some sectors, most notably care homes. This highlighted the national absence of oversight for care homes and its workforce, and the lack of understanding of this sector given the critical role they play in a health and care system. Nursing homes and the nurses that work within them were especially keen to claim

their place within multi-disciplinary teams. The experiences of the system reflect the existing evidence base demonstrating the importance of system working with care homes as an equal partner.[10]

Professional behaviours changed at all levels; decision-makers and front-line staff were motivated by the need to respond quickly and effectively to the crisis. They were empowered by the ability to act autonomously, freed from the usual bureaucratic processes, with particular benefits to front-line staff. There was widespread aspiration to sustain this new way of working, especially where it allowed for joint working across organisations, and to move on from the previously acknowledged challenges in working collaboratively

A strengthened cross-organisational clinical voice emerged from the crisis, with confidence in assuming collective ownership of future services. They will however require improved support, from both the centre and their local system, to sustain energy for change, especially in dealing with the health and care backlog and acuity of need.

Professionals at all levels are confident that the pandemic has accelerated system working and that over time, sustained permission – from system leaders and from national guidance – will lead to true cultural change.

5.2 Recommendations

Recommendation 1: The rapid changes to services that were made as a response to the crisis need to be given time to embed outside of the pandemic. Many were welcomed by staff as changes that had been warranted for years and represented new or innovative ways of service delivery that have the potential to improve staff and patient experience.

Recommendation 2: The system-wide approach to collaborative working modelled through the pandemic response should be consolidated, resourced and continued. The weaknesses at the interfaces, especially related to care homes, should be addressed through interventions that promote joint-working.

Recommendation 3: The system needs to plan for the cohort of patients expected to have long-term needs following initial recovery from COVID-19. As the evidence emerges as to what these needs are likely to be, the combined system lessons from the pandemic can be used to design a clinically appropriate pathway that can be delivered by a multi-disciplinary team

Recommendation 4: The system's workforce should have equitable access to mental health and wellbeing support, whilst acknowledging needs will be different. Some professionals such as care

[10] Hanratty B, Craig D, Brittain K, Spilsbury K, Vines J, Wilson P. Innovation to enhance health in care homes and evaluation of tools for measuring outcomes of care: rapid evidence synthesis. Health Serv Deliv Res 2019;7(27).

home staff will have already faced trauma and will be severely anxious in future waves of the pandemic. Other services such as cancer are preparing for the tragedy of delayed presentation and may require resilience training to cope.

Recommendation 5: National guidance has to be more sensitively and appropriately interpreted for the local context or risk demoralising staff. For instance, local delivery of the national hospital discharge guidance[11] challenged care homes' value in the health and care system. Continuation of face-to-face consultations in social care and the community whilst primary care moved to virtual working led professionals to question whether they were as valued as much as other professions.

Recommendation 6: Access to safety equipment should be equitable and the responsibility of the system. Front-line staff should have access to appropriate PPE and professional concerns around safety should be addressed with immediate effect.

Recommendation 7: A system plan for test, track and trace is required in the absence of national guidance (and lack of tests) to effectively manage future waves of the pandemic. Whilst public health resources may be limited, other forums both clinical and strategic, have already emerged which can usefully support the system.

Recommendation 8: Improved utilisation of virtual consultations in all settings should be encouraged post-pandemic, particularly for patients requiring efficiency and ease in accessing appointments. It should however be at the discretion of individual services to provide the balance between face-to-face and virtual appointments, given they are best placed to understand their patient cohorts who see the benefits in virtual approaches but would like the option of choice.

[11] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/hmg-letter-hospital-discharge-guidance-v3.pdf

6. Appendices

Appendix A: Analysis

Appendix B: Topic Guides – Primary Care, Strategic and Patient

Appendix C: Interim Report – Primary Care Findings

Appendix D: Patient Accounts

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