

# NHSE/I Midlands Region

# Learning from COVID-19

## Final Report

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## 1 Introduction

There can be no doubt that the COVID-19 pandemic has had a devastating impact on the lives of countless people across the world. It has brought suffering and tragedy which has been particularly felt by the most vulnerable and disadvantaged. Our care services have been under tremendous pressure but have risen to the challenge with outstanding professionalism and compassion. During this most testing period there have been extraordinary examples of innovation and improvement which offer rich opportunities for learning. And it is in this context that we were commissioned by NHS Midlands to engage with those who have led the response to this national emergency and jointly learn from their experience of recent months.

It has been a privilege to undertake this review. We have been met with real openness and have been struck by the humility of those who achieved so much.

We hope this report offers valuable insight and lessons for the future. Above all we would like to think it also serves as a tribute to the work of all those involved in the delivery of care services across the Midlands.

## 2 Setting the Scene

### 2.1 Context

During the early weeks of 2020 it became increasingly clear that the United Kingdom was facing an unprecedented public health emergency. On the 30<sup>th</sup> January the first phase of the NHS's preparation and response to COVID-19 was triggered with the declaration of a Level 4 National Incident. Specified governance and incident control arrangements were established, and a multi-faceted response was mobilised. Incident control centres were set up within and across every NHS funded organisation with rigorous regional and national co-ordination.

The situation developed rapidly and at scale. The statistics are stark and sobering;

From the start of the COVID-19 pandemic to the end of July there were 20,280 admissions of COVID-19 positive patients into hospitals in our region, almost 20% of the total admissions in England. Tragically there has been 5,867 deaths in our hospitals as a result of COVID-19.

At its peak there were 500 ventilated patients in Midlands hospitals with 3,000 beds occupied.

And as the crisis developed it became increasingly clear that the impact on residents of care homes was particularly and tragically significant.

We should also not underestimate the impact on our workforce. Our staff have shown remarkable dedication in looking after the sickest patients while putting themselves at risk of infection. At its peak there were over 20,000 NHS colleagues absent from work across the Midlands isolating, shielding or having caught COVID-19 itself.

Sadly, across the Region, 37 NHS colleagues have lost their lives and as an NHS family, we extend our sympathies and thoughts to all of those affected by these tragic losses.

The statistics go some way to convey the impact on the population, on individuals and on our staff. But they cannot tell the story of the response to the Pandemic; characterised by partnership, innovation and rapid change. It was this response that we sought to understand in our review, to enable learning and further improvement.

## 2.2 Approach and Methodology

Over the last few weeks, a process of engagement has taken place with STPs/ICSs and the NHSE/I Midlands regional leadership to capture learning from the management of the COVID-19 incident. The outcomes of this work are intended to enable the adoption of proven good practice, inform the restoration and recovery process and assist the work of the Regional System Transformation and Recovery (STaR) Board.

Our methodology has been relatively straightforward, each system has made a written submission based on their experiences of the last few months and we have then convened a review conversation with their leaders. An example of the submission format can be seen in appendix 3. In order to give the systems an adequate opportunity to reflect on and share their areas of significant learning we adopted a methodology of collect, assess and review;

- Collect summary information against six domains in a simple framework. The domains are; Governance, Clinical and Quality Processes, Support Processes, People, Inequalities and Leadership and Culture.
- Assess the information to build a picture of key achievements and challenges
- Review through a 1.5-hour reflection session held with system representatives to focus on and explore significant areas of learning and innovation.

It has been invaluable to have the AHSNs alongside us as we have progressed this process and we have also benefitted from the input of the national Behavioural Change Unit.

Upon completion of the review process and having considered the key themes and learning our findings and recommendations are structured under the following headings;

1. Full system working
2. A focus on place
3. Continuous innovation, improvement, spread and adoption
4. Using technology to improve care delivery
5. Supporting the health and wellbeing of staff
6. A new workforce – well led, flexible with talent shining through
7. Addressing inequalities and supporting the most vulnerable
8. A new relationship with the public
9. Developing the NHSE/I relationship with the local NHS

### 3 Summary Observations

The overwhelming nature of the feedback and reflection we have received has been positive despite the unprecedented level of challenge involved. There was collective pride in the responsive action which was mobilised and in many specific improvements and innovations. There was however a consistent acknowledgement of lives lost or damaged across the population and amongst public servants. Anything reported here must be seen in this context together with the collective determination to learn from the experience so that improvements can be made in the future management of the Pandemic or embedded into mainstream practice.

Every system described their own distinctive experience of managing the pandemic. Indeed, one of our overall observations relates to the ability of local leadership and local partnerships to work effectively when offered space and trust to do so within a clear national framework.

There were however some consistent and general message we heard from all systems which we summarise here before setting out more detailed findings and recommendations.

The clear and common purpose which was understood by all health and care bodies and their staff was hugely empowering. This was supported by a strong sense of freedom to act. The robust governance arrangements that were implemented were felt to be supportive, enabling rapid decision making and implementation.

The removal of the existing financial arrangements facilitated cross organisational working. Investment decisions were fast tracked, often in care delivery models which crossed organisational boundaries.

We heard about the high levels of energy from staff with the emergence of new leaders from a range of organisations and professions, many with clinical backgrounds. This assisted the adoption and spread of new approaches.

All systems reflected on their focus on Place. This was where services and multi-organisational responses came together and there was a clear desire from systems to continue with Place as a central feature of their continued transformation and improvement plans.

There were of course numerous difficulties to overcome and we heard about the constantly changing guidance on PPE, often with short timescales. There was also frustration about the variable access to national data to enable fast and accurate local decision making. And many systems shared a sense that the pandemic had starkly highlighted the greater attention which needs to be given to population health and health inequalities.

## 4 Key Findings and Recommendations

### 4.1 Full system working

All our reviews have highlighted the significant benefits associated with a system level response to the pandemic. Clear governance arrangements were established, and organisational leaders came together to direct necessary action within the context of a national level four emergency. Rapid action relating to prevention, care delivery, capacity, resource deployment and investment was taken across the NHS and between the NHS and key partners, particularly local government.

Impressive progress was achieved, born partly out of necessity and a clear common purpose but also driven by a growing understanding of the ability to deliver rapid change when a system rather than organisational perspective is adopted. All Midlands systems have clearly shown they can operate effectively in the most challenging circumstances.

We take it as a given that all 11 Midland systems will become ICSs by April 2021. To ensure they can fulfil their potential and can lead our care systems through the recovery, restoration and subsequent phases, we recommend:

#### Recommendations

1. Appropriate governance arrangements, aligned with the ICS minimum requirements, are established so system leaders have the authority and accountability for delivery on key quality, preventative, service delivery and financial priorities.
2. Action is taken to ensure all systems have the leadership capacity and capability with adequate supporting resources. If necessary, expertise and resources should be shared across two or more systems.
3. The financial regime is developed to re-enforce system working. This will include the primacy of system funding envelopes, a movement from tariff to blended payment models and capital planning processes which are led at a system level.
4. All systems are required to demonstrate their capabilities to lead improvement and change processes, building on the advances made during the COVID-19 pandemic and anticipating the need for large scale service change in the future.
5. The role of CCGs in future system working is clarified within the context of an ICS. We have observed the benefits which were evident during the pandemic as many adopted a planning, co-ordination and leadership role rather than one characterised by contractual transaction.
6. Local government plays a full role in all system working, not as an “invitee” but as an integral active constituent contributing to all work programmes. This should be underpinned by appropriate governance and accountability arrangements.

7. NHSE/I re-enforce system working by continuing to interact significantly with system leaders on all key planning and delivery priorities.

## 4.2 A focus on place

Our reviews have not only highlighted the importance of effective systems but have also emphasised the positive impact which can be achieved by dynamic place-based working. Such working enabled active community engagement, the rapid mobilisation of care delivery and preventative models which met the distinctive needs of local populations and facilitated new workforce contributions.

During a period of national command and control we saw a liberation of leadership, with contributions from primary care, local government, community leaders and the third sector at a local level. We are struck by the potential to build on this in the future and to see place-based working as a critical element in the future care landscape. We therefore recommend:

### Recommendations

8. All existing or prospective ICS development plans, which should be constructed in collaboration with place leaders, should clarify how place-based working will be rapidly progressed.
9. System strategic plans will specify areas of priority for each place within the context of the overarching system plan. These are likely to include community engagement, prevention, health inequalities, networked primary care, integrated community care and social care. However, the specific areas of priority will reflect distinctive local circumstances.
10. The advances in data and information sharing which has occurred in the pandemic are “locked in”. These are critical to effective collaboration and the enablement of new models of care.
11. All opportunities to sustain workforce flexibilities within unified place-based teams are pursued.
12. Governance arrangements are enabling rather than restrictive, encouraging the active participation of community leaders, local government, public health specialists, third sector as well as the NHS.
13. ICSs ensure adequate resources are provided to place leadership teams to enable positive impact. This will include data management, change management and improvement science expertise.

## 4.3 Continuous innovation, improvement, spread and adoption

Before COVID-19 there was countless research papers which described the barriers to innovation, improvement, adoption and spread. Obstacles included poorly aligned financial incentives, organisational silos, clinical resistance and a risk averse culture that resides within many NHS organisations.

As part of the review process we heard that a culture embracing innovation and improvement rapidly evolved. Challenging the barriers to innovation, adoption and spread will, however, require ongoing focus and commitment. Enablers should be put in place to sustain and embed the rapid spread and adoption of new ways of working. Cultural change and blended teams have proven to be pivotal in driving through innovation and improvement during the pandemic. This cohesive working should be sustained going forward.

At the peak of the pandemic there appears to have been a rare moment; people across the regional and local systems had a clear sense of their defining purpose and were able to build a clear consensus on action. They were then able to tap into practical innovation and improvement support from across the healthcare system, including organisations such as the AHSN's, the Clinical Senate and the voluntary sector.

Systems should seek to learn relevant lessons and capitalise on the accelerated decision-making opportunities. They should moreover carefully evaluate all recent innovations and improvements to decide which they should retain, adapt, or reject. We recommend:

### Recommendations

14. An NHSE/I Midlands Innovation Plan is developed, alongside associated system-wide plans detailing key innovation and adoption programmes, incorporating the very best improvements which were implemented during the COVID-19 response.
15. NHSE/I and systems should address variability in the response from primary care. There have been some examples of innovation and leadership and the creation of new care pathways. There needs however, to be a consistent approach across primary care to ensure full engagement in system planning and implementation activities. It appears that primary care developments at place level appear to have been easier to progress than at overall system level.
16. Clinicians should continue to deploy specialist knowledge and expertise in order to respond to specific challenges and deliver improvements in services across care settings. We have seen a rapid rise in the influence of the specialist clinical perspective enabled in part by an understanding that this expertise needs to be trusted rather than channelled through extended review and approval processes.
17. There should be an acceleration and embedding of community-based care delivery models. These should include admission avoidance, accelerated discharge and remote domestic support programmes. Many of these were in place previously but circumstances have led to a very rapid scaling up of their coverage and the introduction of innovative technologies to support care giving. The continued co-ordination between acute, community, primary care, social care and third sector teams is vital.
18. NHSE/I should conduct an evidence based strategic review of innovations, technologies and enhanced ways of working on an annual basis. This should be an integral programme across the region supported by the AHSNs and NIHR organisations.



19. Implementation support and training should be provided to ensure maximum benefit is gained and a culture of continuous innovation and improvement is considered the “norm”.
20. The development and adoption of a consistent approach to improvement science and change methodology across the Midlands with a requirement for improvement expertise and practitioners in every system.

#### 4.4 Using Technology to improve care delivery

During the COVID-19 pandemic we have witnessed virtually all NHS and Social Care organisations adopting digital technologies at an astonishing pace. For example, at the end of 2019 NHS Digital was reporting that of the 23 million primary care appointments carried out during December, 15 percent of those appointments were conducted by phone or online. By the end of May 2020 many Midlands GP practices were reporting that they were conducting almost 90 percent by phone or online. We are beginning to see the same level of digital transformation across outpatients’ services and a wide range of digital approaches in pharmacy and community health services. We recommend:

##### Recommendations

21. The continued use of technology to assist the delivery. Remote GP consultations, outpatient clinics and remote monitoring for care homes, should become normalised.
22. Systems should undertake a thorough evidence-based evaluation of the changes adopted during the COVID-19 pandemic. Benefits, risks and implementation support requirements including staff training need to be identified.
23. Continued co-production of new technology pathways should occur with the involvement of all parts of the system across multiple disciplines. Blended teams, involving clinicians and digital experts should be constructed to address key delivery challenges to enable diversity of thinking and stronger outputs.
24. Systems should be kept abreast of new technologies and improvements capabilities by ensuring high quality horizon scanning is undertaken. This should go alongside a requirement for systems to articulate real time unmet needs. Our AHSNs could co-ordinate relevant work in the West and East Midlands and ensure appropriate interaction with procurement frameworks which must be more receptive to innovation.

#### 4.5 Supporting the health and wellbeing of staff

As the nation underwent lockdown a spotlight was shone on NHS and care staff who then became the centre of concern and support with weekly clapping, donations and fund raising. Huge concern was expressed about their safety and many efforts were made to utilise local and national systems to secure PPE and provide the necessary frameworks to ensure safe working practice. As more became known the additional

risks to BAME staff were highlighted and further work including risk assessments were undertaken to allow for increased support.

Despite this, it was clear that the situation was not always ideal with systems and organisations sometimes left unclear about the level of freedom to act and at times some specific details. They felt under considerable pressure and scrutiny to ensure their staff were properly supported.

Staff from a wide range of professions and roles described themselves conflicted with both a sense of professional pride and safety fears. Organisations responded actively with heightened communications programmes, occupational health support, enhanced training and mental health support.

Systems described many of their staff, including senior leaders, as 'worn out' and concerned about their ability to sustain prolonged periods of further intense COVID-19 management along with restoration and recovery. They also expressed concern about the longer-term impact on staff well-being including PTSD type symptoms. We therefore recommend:

### Recommendations

25. A clear and honest assessment of staff morale is regularly carried out at system level including partners views.
26. Actions in keeping with the People Plan are developed by the Midlands People Board which should take account of the findings of this review.
27. Systems should review relevant facilities and provide enough opportunities for staff to rest and recuperate in time for winter pressures.
28. NHS Midlands takes forward the 'resilience hubs' and improved occupational health initiatives set out in the People Plan as part of national pilots.
29. Leaders are identified who will lead and role model behaviours that will enable staff to switch off from work and maintain a positive work/life balance.
30. Risk assessments for all vulnerable staff are fully completed as a matter of urgency.
31. The Midlands People Board work with PTSD expertise to inform staff mental health support programmes.

## 4.6 A new workforce- well led, flexible with talent shining through

As the pandemic unfolded the health and care workforce responded incredibly positively with many returning to the front line and offering their skills and knowledge. We heard of many examples of staff working outside their usual remit, working in different teams, adopting new work patterns and practicing in different locations. We learnt of rapid deployments, accelerated training and induction, faster recruitment and a large-scale take-up of home working. The successful move to home working required huge scale IT support and refinement of processes as well as massive changes to home life which for many had to be accommodated along with other changes to previous routines.

Leaders took up the challenge of a 'command and control' infrastructure by engaging more with their staff and stakeholders, strengthening communications and ensuring greater visibility which was well received. As the objective was often clear and single purposed, a different working culture emerged. Many felt empowered with opportunities to apply local discretion and enact rapid change.

The timely roll out of new patient pathways, new technologies and a greater focus on delivering care at the place level inspired a new cadre of leaders. Many were clinicians who took up informal leadership roles as a personal response to the new demands they and their colleagues faced.

Whilst the increased visibility of leaders, culture of empowerment, flexibility of staff and emergent leaders are to be welcomed they will need active support if this is to be sustained in the coming months and beyond. Considering this we recommend:

### Recommendations

32. Rapid mainstreaming of the HR processes across systems which facilitate staff flexibility such as staff passports, standardised recruitment, OH assessments, induction, training and leadership development.
33. Greater support to the development of place teams with the necessary leadership and support infrastructure allowing place to take precedence over organisation.
34. Systems should review new roles developed as part of the COVID-19 response with a view to making them permanent if beneficial.
35. Development of local case studies and examples led by staff on the recent culture of empowerment and permission to act. These can be shared to support systems change and leadership development programmes.
36. Support should be provided to new leaders to capture their learning and continue their personal development. This could include virtual learning sets across systems to share experiences and widen networks.
37. Opportunities should be created for senior leaders to express their personal learning during this most demanding of times with individual support plans being agreed by their line manager.
38. A review of the current approach to leadership development and talent management is undertaken. This should enable a more distributed leadership model with an emphasis on harnessing skills rather than a traditional and linear hierarchical approach. The aim should also be to encourage a more diverse range of future leaders from a wider range of backgrounds and roles.

## 4.7 Addressing inequalities and supporting the most vulnerable

As the tragic impact of the pandemic began to crystallise it became increasingly clear that it was having a disproportionate impact on certain groups in the population. The incidence of COVID-19 and associated mortality levels was higher within ethnic communities, in those facing socio-economic challenge, in the elderly (particularly

those in care homes) and in several vulnerable groups, including for example, those with learning disabilities.

Analysis seems to indicate that the pandemic has starkly exposed and highlighted the underlying health inequalities which exist in our society. These inequalities relate to health and wellbeing status, to relevant outcomes and to access to health and care services. We therefore asked all systems to describe the approach they have adopted to address health inequalities as a key theme in our lessons learned review. We were also interested in how they would intend to build on their learning in the future.

We heard some impressive examples of work to support at risk groups including BAME communities and the homeless. The benefits of closer working between health, local government, public health specialists and the third sector were also emphasised. However, much of what we heard was very reactive and tactical and we did not feel reassured that comprehensive and coherent work programmes are in place to reduce inequalities to acceptable levels. The NHS remains, it appears, pre-occupied with diagnostic and treatment services rather than population health and inequalities. We therefore recommend:

## Recommendations

39. NHSE/I Midlands continues to position health inequalities as a regional priority and gives full support and prominence to the inequalities workstream being taken forward as part of the Strategic Transformation and Recovery Programme.
40. All ICSs/STPs and placed based bodies are required to adopt population health, prevention and health inequalities as a core priority and to set ambitious goals and objectives for improvement. We see particularly strong prospects for positive impact at place level- based on active partnerships between NHS providers, local government, primary care, public health specialists, third sector and local communities.
41. All healthcare providers should make significant contributions, recognising every interaction in primary, community and secondary care offers an opportunity for health improvement. All Trusts and primary care providers should therefore be required to specify the work programmes they will pursue, particularly in relation to secondary prevention and health improvement.
42. There should be a strong focus, at regional, system, place and organisational level, on the health and wellbeing of the most vulnerable. This will require full engagement with community and third sector groups and new, supportive relationships with care homes.
43. All relevant bodies have common access to relevant information about the determinants of ill health, patterns of inequality, local population health data and the efficacy of interventional options. This should be co-ordinated regionally and by local Public Health teams. This will be particularly important as the potentially differential impact of COVID-19 on socio-economic issues, physical and mental health and social cohesion becomes evident.
44. The essential capabilities of all existing and future NHS leaders should include expertise, insight and skills relating to population health improvement health inequalities. This should be supported by a development programme.

45. Action to address health inequalities starts now. It should be an active consideration in the continuing management of the pandemic and steer many aspects of the restoration and recovery work.

#### 4.8 A new relationship with the public

We were impressed to hear how much attention was given by systems to their engagement with the public; to provide local information about the pandemic, to offer relevant guidance and advice and to secure views about new service delivery models. This engagement took place in a variety of different ways, through social media, mainstream media, patient groups and public advocacy groups including Health Watch.

The distinctive impact of good, locally tailored communication was evident. Many of the changed service delivery models involve remote, digitally enabled interactions with patients and a growth in supported self-care and out of hospital care. We heard, for example, about some very positive examples of the extended use of social prescribing. And, of course, we witnessed a massive expression of public admiration and loyalty to the NHS as the pandemic developed. Taken together we believe there is potential for a new relationship, based on partnership rather than paternalism that can be fostered between the NHS and the public.

#### Recommendations

46. All NHS bodies continue to use a variety of communication methods to keep their local communities updated and informed about relevant matters regarding the pandemic and their restoration and recovery plans. In some cases, the communication approaches will need to be bespoke to the target groups.
47. Priority is given to continuous engagement about new service delivery models. Their impact on all parts of the local population should be assessed so appropriate adjustment can be made.
48. Particular attention is given to reaching out and connecting with those communities and groups which experience the most difficulty accessing services and suffer poorer outcomes.
49. The NHS continues to welcome volunteers to assist the delivery of care in all healthcare settings including the home.
50. The NHS works in partnership with local government and third sector to explore options, including social prescribing, for care delivery which empowers and encourages independence.
51. There is a rapid and positive response to the significant growth in interest in working for the NHS. An active but measured programme of recruitment should be progressed.

## 4.9 Developing the NHSE/I relationship with the local NHS

The scope of our review extended to the work of NHSE/I Midlands and their relationship with the local NHS. We discussed this with all systems and held a separate session with the regional leadership team. We heard about many positive aspects; the cell structure enabling the deployment of specialist expertise, the emphasis on clinical and patient safety considerations, the regularity and openness of communication, regional colleagues working as part of system teams and an overall sense, somewhat paradoxical in a command and control context, that the relationship became more empowering with more space for local discretion and improvement rather than hierarchical regulation and intervention. These observations were shared by both system and regional colleagues who also described the benefits of a rapid switch to new, remote working arrangements. We also heard some frustrations about, for example, the timely availability of modelling data, the management of PPE and the confusion associated with some policy announcements. These were acknowledged, as was the underlying complexity of the situation and the relative contributions of national and regional bodies.

We conducted our review as the restoration phase was developing and we heard concerns about a reversion to a relationship between NHSE/I and local systems which fails to capitalise on the many positive aspects described above. Whilst this is, to a degree, inevitable we also see opportunities to build on the learning from the management of the pandemic and therefore recommend;

### Recommendations

52. Some regional resources are substantively transferred into the emerging systems. This will support their development and enable the evolution of NHSE/I as a leaner body focussing on strategic leadership, improvement and targeted intervention.
53. Review existing team structures, particularly unfilled posts, to ensure that recent cell arrangements and the focus on system working are adequately reflected.
54. NHSE/I Midlands continue to create and draw on networks of specialist expertise to guide the continuing management of the pandemic and to inform critical aspects of the restoration and recovery phase- for example the challenge associated with rebuilding diagnostic capacity.
55. NHSE/I and the NHS across the Midlands maintains a focus on its declared priorities- inequalities, clinical quality and people. We see the work of the STaR Board and its sub-groups as being critical in this regard with a requirement for rapid, inclusive planning processes leading to decisive action.
56. NHSE/I promote and support the development of each system recognising they will have their distinctive needs and challenges. Processes and incentives should increasingly be orientated to systems rather than organisations. NHSE/I should ensure systems have adequate leadership and supporting resources, some of which may need to be shared across systems.
57. NHSE/I explore the opportunities associated with the development of a Midlands Faculty for Improvement. This would bring together analytical expertise, improvement practitioners, digital experts and organisational development

specialists. This would be integrational and offer a common source of high calibre support to systems and place bodies as they move through the restoration and recovery phases. The resources to populate such a faculty already exist and discussions with the AHSN's should be embarked upon in order to maximise the potential of the Faculty.

## 5 Summary

The review process has been positive and informative. It has provided many examples of outstanding practice and a wealth of opportunities for sustained improvement. We believe that the recommendations above should be considered by key regional leadership groups as well as each system. Not all will be relevant to all care systems across the Midlands and it will be for local leaders to determine which should be prioritised and adopted.

We have been struck by the appetite for learning and improvement which exists. We therefore think a further review of progress and a stocktake of reflection and learning would be helpful in November to assure progress and support the spread of best practice.

We would like to take this opportunity to thank Kim Silvester, James Ilott, Jessica Sokolov and Philippa Hunt for their contribution to the review process.

## 6 Appendices

### 6.1 Examples of Best Practice

During our review we heard numerous examples of good practice across our 6 domains of interest. We heard many similar examples of good practice and have chosen to reflect ones that came from just one system below. We heard about new significant developments in leadership style and a change in system culture which underpins all the examples below and the positive finding described in our report.

Domain	System	Examples of good practice	Synopsis
<b>Governance</b>	BSOL	COVID-19 Health Protection Board- Solihull	A decision-making group established at place level in Solihull, with a remit to deliver against and clear terms of reference.
	Staffordshire	Revisions and streamlining of organisational governance arrangements	A risk-based approach to governance with the use of MS Teams for governance including modified arrangements for public access and questions. A rapid action decision making process implemented for COVID-19 related items within organisational governance arrangements.
<b>Clinical &amp; Quality Processes</b>	Leicestershire	The design of 10 system expectations and their associated actions and a reset model of care	In support of restoration, recovery and reset, a rapid clinically led system process established to capture key learning to inform ten expectations the system must adopt and embed going forward and against a revised model of care.
	Lincolnshire	Operational services scale back plan	LPFT comprehensive review of existing services resulting in a robust 'Operational Services Scale Back Plan' that focused upon varied modelling forecasts that would ensure continuance of key services.
	Herefordshire & Worcestershire	System wide ethics forum and System wide ethical framework	Shared space for clinical leaders to deliver a response with a single set of documentation for admission decision and community



			pathways for COVID-19. Shared learning and transparency developed of individual providers response to planning approach across general practice, community, hospices and acute settings.
	BSOL	Confidential online MH advice and support service for CYP	Provided by Kooth the provision offers timely and confidential access to a range of mental health support for CYP. The intelligence produced by Kooth provides real time feedback on CYP mental health needs locally and benchmarks this against other areas who use this service.
	Derbyshire	Florence Nightingale Care Home	A Florence Nightingale care home was opened mid-June which was solely for the use of those patients coming out of hospital who were COVID-19 positive.
	Lincolnshire	Establishment of system Ethics Committee	System wide forum where any ethical decisions/dilemmas could be debated to formulate a system recommendation on the appropriate action to take. Led by an Independent respected Chair, plus senior representatives from across the system organisations.
<b>Support Processes</b>	Northamptonshire	Leadership of BI teams across organisational boundaries	One individual overseeing the BI teams across organisational boundaries in LA and CCG. LA CEOs have agreed for a single BI function through a S75 agreement with health.
	Shropshire & Telford & Wrekin	System Strategic Evaluation Hub	A benefits realisation hub that enabled the integration of performance, finance and quality data with predictive modelling software (Simul8) that would support the restore and recovery groups as the system moves forward into recovery.
	Nottinghamshire	Primary Care and General Practice OPEL reporting system	A reporting process involving practice managers and locality teams was developed and implemented as part of wider system daily OPEL reports to support system escalation and triggers.
<b>People</b>	BSOL	System wide MoU for movement of staff across the system and to deliver Nightingale Hospital.	Sharing of best practice, reduction in policy variance between Trusts, peer support, collective voice with wider system partners e.g. Local Education Authority. Improved support offers negotiated

			and available for staff. Shared approach to passporting staff, understanding skills required, provision of induction, training and development, paying staff and standing them down whilst maintaining engagement.
	Northamptonshire	Virtual Wellbeing Festival	A weeklong virtual wellbeing festival across the system with several different sessions facilitated by national leaders, famous personalities etc.
	Coventry & Warwickshire	System wide psychological and emotional support offer	A system-wide psychological and emotional support offer commenced from CWPT. Over time the scheme will not only support staff but also communities and work has commenced with LAs to feed this into the Place based work being undertaken with communities.
<b>Inequalities</b>	Nottinghamshire	Multi agency wrap around services for rough sleepers	Multi-agency task group set up hotel accommodation within 1 week with support workers, health (nursing & GP & mental health) provision, housing & benefits agencies, homeless charities, LA and CCG.
	Herefordshire & Worcestershire	Community Action response for the vulnerable	Local authority led support to localities based around need and organised through strong place based integrated leadership delivered through third sector/voluntary organisations.
	Coventry & Warwickshire	Operation Shield	Provision of support (including food, medicines and social contact) for c.14,000 in Coventry identified by NHSE/I as Extremely Vulnerable Person (EVP) and required to shield for 12 weeks.
	Black Country	STP Academy	The STP Academy will collaboratively develop system wide outcomes. This will improve cohesive system wide effort in reducing multifactorial inequalities.

## 6.2 COVID-19 experience case studies

The East Midlands AHSN have worked with local stakeholders to capture personal experiences during COVID-19. The following case studies provide a range of perspectives and experiences of the health and care system during COVID-19.

***Dr Julie Barker, GP, End of Life lead and member of Care Home cell. Clinical Design Authority clinical lead for Nottingham Nottinghamshire Integrated Care System (ICS)***



Care home Cell  
Clinical Lead - COVID

***Joanne Taplin, GP Partner – Abbey Medical Centre, Beeston, Nottinghamshire. GP team member working with Notts West PCN Advance Care Planning Nurses.***



GP partner - COVID  
experiences.pdf

### ***Patient case study***



Patient case study -  
COVID experiences.c

***Jane Borland, Care Home Manager–Rathgar Care Home, Northamptonshire***



Rathgar care home  
- COVID experiences

***Combined response from four Pharmacists at PCT Healthcare Limited, Derbyshire.***



Combined  
response PCT Health

**Dr Sarah Linford, Critical Care Consultant in Nottingham University Hospitals, Intensive care**



Dr Linford case study in template NI

**Andrea Smith, Superintendent Pharmacist – B J Wilson Ltd, Derbyshire.**



Superintendent Pharmacist BJ Wilso

**Lindsey Fairbrother, Superintendent Pharmacist – Good Life Pharmacy Ltd, Derbyshire.**



Superintendent Pharmacist Derbyshi

## 6.3 Documents to support our approach

Lessons learnt framework submitted by each of the 11 systems to demonstrate areas of best practice and significant learning.



Lessons learnt framework- review c

Letter of invitation sent to the 11 systems to participate in the lessons learnt review process.



Learing letter to systems\_final\_5.6.20