NHS
East of England
Clinical Senate

The Regional COVID-19 pandemic response and system learning.

What have we learned about how health care can be delivered during the last twelve weeks?

East of England Clinical Senate Council

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Foreword from Clinical Senate Chair

Health and Social Care in the East of England, like the rest of the United Kingdom and indeed most countries in the world, have had to face immense challenges over recent months and will no doubt continue to do so for many months ahead as a result of the COVID-19 pandemic. The scale and pace of change in terms of working practices has perhaps been more marked than for over half a century. The emotional impact on staff working in all sectors has also been profound. The Clinical Senate Council took time to reflect on all that has happened with a focus on what we should adopt, adapt and abandon.

I am fortunate to chair a Council of dedicated professionals and experts by experience from across all the STP/ICS footprints, including every county and including over twenty organisations from a wide range of sectors in the East of England. This enabled us to reflect on the differing impact of the pandemic on patients and staff from primary, community, mental health, secondary and tertiary care sectors. We were also able to draw on the very differing impact of the rate and peak of the surge in differing parts of the region.

One clear reality is that our staff in the East of England have responded in remarkable ways, demonstrating their dedication with a willingness to go beyond the call of duty and indeed to continue to deliver the highest quality compassionate care they could despite potentially being at some risk themselves.

There have been many clear positives in terms of the way staff and organisations have responded with a willingness to collaborate, innovate, re-train, move at pace, re-locate and work long days and weeks to deliver the best care for patients.

We recognise that we will not have covered everything in our discussion and deliberations, however the content of this report including the recommendations were the ideas and views generated by our Senate Council leading up to the council meeting (of 24 June 2020) and during the meeting itself. In seeking feedback before finalising the report, perhaps one area we did not cover sufficiently was the ethical aspects of the Health and Care systems response.

We have not looked at the National response in terms of timing of the initial lockdown and the measures taken during the easing of the lockdown and perhaps these matters could be explored at a more National level. As the report states, many lessons do need to be learned particularly regarding clearer and consistent messaging, more robust supply of PPE, better support for social care and care homes, and ensuring that facilities are better designed for second surges and future pandemics.

The NICE guidance (COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services) published 27 July 2020[1] was not available to us during our discussion and was therefore not considered. I do however note that there was a strong view for maintaining a protected elective pathway including appropriate facilities both in terms of a response to this and other pandemics and usual NHS (rather than winter) pressures. Whether the NICE guidance provides sufficient protection for vulnerable patients and staff from vulnerable groups from other patient groups with a reduced isolation period and a reduced need to test pre-diagnostic procedures is perhaps a discussion point we may wish to revisit.

I would like to reiterate my thanks to all Health and Care staff in the East of England and to the Clinical Senate Council for their time and expertise helping to generate this report.

Dr Bernard Brett

East of England Clinical Senate Chair

[1] https://www.nice.org.uk/guidance/ng179/resources/covid19-rapid-guideline-arranging-planned-care-in-hospitals-and-diagnostic-services-pdf-66141969613765

The Regional COVID-19 pandemic response and system learning. What have we learned about how health care can be delivered during the last twelve weeks?

This short paper summarises the discussion of East of England Clinical Senate Council on 24 June 2020 and presents its key findings and recommendations. Members of Clinical Senate Council include clinicians from a range of clinical professions, specialities and settings and non clinical members (experts by experience). The range includes members from all six STP/ICS' in the East of England and from primary, community, secondary, mental health and ambulance service backgrounds. Members brought their own experiences and perspectives to the discussion with a view to summarising whether the changes made in the course of responding to the COVID-19 incident, could be adopted, adapted or abandoned as the health and care services look to restore services for patients.

Key Findings

Despite the range of clinical and non-clinical backgrounds and health and care settings, during the discussion it became clear that there were common themes. The key findings below have been grouped under those themes

1) Innovation

a) **Speed**. The speed of implementation of innovation was unprecedented and welcomed. This was possible as a result of staff willingness and engagement, the management approach and digital support. There was an obvious 'can do' approach, rapid solutions to delivery of health care (see also Information technology below), enabled through some reduction and / or speeding up of formal decision-making processes and governance;

b) **Information technology**. Much of the speed of implementation was enabled by information technology (IT), not least the rapid implementation of telephone and / or video consultations for patients in primary, secondary, and mental health care settings. Automated and self-service robotic systems were developed that required no administrative support once implemented (i.e. a self-service toolkit for COVID-19 testing ESNEFT or staff risk assessments in Norfolk & Waveney). There was increased use of pulse oximetry, thermometers and blood pressure machines (for example) in particular patients' homes and in care homes to help clinical decision making.

Tele-conferencing and live-streaming events facilitated easier and improved cross-site working, improved accessibility of clinical supervision and provided an opportunity for enhanced staff engagement during a period of rapid change. Training events continued despite the social distancing restrictions.

c) **Staff working from home** (WFH) Significant numbers of staff moved from their usual office base to working from home. Whilst there were benefits, for example carbon footprint reduction, more efficient use of time with less spent travelling to meetings, and potential savings in terms of estates, there are also challenges to be addressed. These include ensuring staff have appropriate and safe equipment in their place of work, are able to achieve a work / life balance, able to continue contact with colleagues to ensure well-being, and the significant challenge for many having to combine WFH with home schooling or caring for other dependents.

2) Patient experience (this refers to health care for patients not being treated for COVID-19)

a) **Patient journey**. Information technology has been mentioned above. Telephone and / or video consultations (tele-consultations) enabled patients with long term conditions or who were 'shielded' to keep safe within their own homes whilst still being able to access healthcare. Although Clinical Senate Council supported this approach and agreed it should continue, it was clear that this should only be when suitable for a particular patient and that in many situations there would be a need for in-person face to face assessment and / or physical examination by a medical professional. Tele-consultations also offered the potential for better 'out of hours' service, particularly for mental health provision; although for group interventions and for supporting some mental health conditions, including those with severe psychosis, cognitive impairment or learning disabilities, tele-consultations are not appropriate.

b) Improved awareness and management of **infection prevention and control** was rapidly delivered across all settings but particularly in primary care and social and community care settings where in the past there has been less focus in these settings. The lessons learned should better prepare us not just for other pandemics but for managing seasonal and endemic infectious diseases. The importance of protected elective capacity has been particularly emphasised and the need for **'Green'** (non-COVID-19) elective facilities within sites and they should continue to be protected. Senate Council agreed that with the right systems and processes in place, hospitals and GP surgeries would be safe places to attend and a major priority is to get this

message out to the general public to reduce the risk of patients declining investigations and treatments for fear and anxiety related to COVID-19.

c) Through necessity, healthcare providers have to ensure that treatment should be determined by **priority order** and likely impact on clinical outcomes and not waiting list order. More sophisticated methods for **risk stratification** and segmentation of patients to deliver the best clinical outcome for our population were seen as being beneficial and have been utilised to good effect (for example the use of FIT[2] testing to determine the risk of colorectal cancer).

d) There should be more proactive engagement with **care homes** (primarily from primary care), with routine use of the frailty score, care planning and treatment escalation for all patients in the **last years of life** and an understanding of different bereavement support and rituals.

e) There has been an increased **Mental health** awareness and understanding of the need for support. Primary care in some areas have been involved in proactively contacting vulnerable patients to provide additional mental and physical health support. We need new ways of working to provide better understanding and awareness of people's mental health and well-being and how that can be managed. Making sense of the rapid changes needs time and there are many health and care professionals in communities who perhaps traditionally focus more on physical health and social needs rather than mental health needs that could learn techniques to provide such support.

f) **Community care and vulnerable groups**. The support to the homeless, rough sleepers, traveller community and other vulnerable and hard to reach groups needs to be addressed including the processing of Asylum Seekers. These groups of the population have been particularly vulnerable to the impact of the COVID-19 pandemic. The support has been seen to be slow, inadequate and even non-existent in some areas. Their general lack of access to technology compounds their vulnerability and inability to access any health or care provision or be reached by providers.

g) We need to reflect on the **unintended consequences** of focusing on one acute health issue to the potential detriment of other aspects of care. For example, COVID-19 itself did not have a huge impact on paediatrics or neonatal services but it definitely

[2] Faecal Immunochemical Test https://www.faecal-immunochemical-test.co.uk/

impacted negatively on vulnerable children. There were also potential risks to neonatal care due to staff being redeployed to other areas and an exacerbation of inequalities in maternity services was also observed.

h) The **restriction, or ban, on visiting** had significant unintended consequences for some groups of patients. For example, particularly in neonatal and paediatrics units where there is a partner in care situation, the restriction will have impacted on parental bonding and potentially even neurodevelopment. There was also a profound impact on those living with dementia or receiving end of life care.

3) Process

a) **Diagnostics**. Rapid diagnostics enable faster and appropriate treatment for patients. It became clear during the COVID-19 incident that East of England has, in general, had relatively poor general diagnostic provision and particularly poor provision for molecular pathology. Some Pathology and Laboratory IT systems are dated and this hampered sharing of information across sites, trusts and with primary care. The response of academic institutions and colleagues in some areas has been remarkable with the Norwich Research Park notably enabling a step-change increase in rapid molecular diagnostic testing. Radiological and endoscopic diagnostics were already under pressure in the system in terms of capacity and have been severely impacted by the pandemic and the requirement to provide facilities for different pathways and patient groups has been challenging. Enhanced capacity with careful consideration for protecting elective pathways and ensuring appropriate space for social distancing and air exchange systems to decrease room turnaround times all needs to be considered.

b) **Pandemic and emergency planning**. Senate Council expressed concern at the lack of clear, consistent and seamless guidance and information issued across the health and care service providers throughout the incident. Information came from multiple sources (e.g. NHS England & NHS Improvement, Public Health England, Royal Colleges) that were often contradictory, with changes almost daily and were sometimes complex without any supporting mechanisms. The Clinical Senate strongly recommends that the whole NHS reflects on the response to ensure a more seamless and consistent approach in future.

c) **Supply chain**. Without wishing to revisit the very public allegations in respect of Personal Protective Equipment (PPE) provision and availability, Senate Council was

clear that in managing a pandemic situation there needed to be a clear and accessible supply chain infrastructure and process from procurement, through to equitable distribution. This is particularly for items that have been, and will in the future, be in high demand such as PPE, other equipment (e.g. ventilators), medicines and hospital oxygen supply. Improvements in two-way communication and a long-term enhancement to reserve stock levels and hospital oxygen supplies must be ensured.

d) The strength of multi-agency, inter-agency and network working was apparent during the incident. Organisational barriers were dropped, and professionals came together to develop solutions that, prior to the incident, would have required formal agreement through respective governance frameworks. Staff involved in such arrangements reported that it had been refreshing, motivating and had direct benefit to their patients / clients. The positive impact was marked, perhaps particularly seen with the huge reduction in delayed transfers of care, freeing up beds to give capacity to manage the potential surge in COVID-19 cases.

4) Workforce

a) The potential impact on Black, Asian and Minority Ethnic (BAME) staff in terms of increased risks and complications of contracting COVID-19 was not clear at the outset and still needs to be better understood. The impact of this differential risk needs to be fully assessed and better understood. The system needs to determine what measures can be put in place to decrease differential risk.

b) The rapid redeployment of staff with accelerated training courses was remarkable. We should focus on the need for a more standardised approach to mandatory training, competencies, recruitment processes, occupational health assessment and other human resource factors to enable more seamless movement of staff across organisations, at least within each STP and ICS.

c) There was major pressure on occupational health services. The pandemic has focussed the needs for all organisations to better support the health and well-being of their staff. We need to consider whether we can do more regarding supporting staff to positively impact on modifiable risk factors including smoking, diet and, as particularly highlighted during the pandemic, obesity. We need to consider generic measures including better training of managers to support the mental well-being of staff and specific measures such as better resourcing of occupational health services.

d) The willingness of many different staff groups to come together and undertake unfamiliar roles, learning new skills and working in different situations should be recorded and applauded. That can only bode well for future cross organisational cohesiveness and delivery of care. However, those moves may not currently be sustainable and the impact is that some staff could be left (longer term) in roles they did not sign up for, and are not suitably trained for, or (as noted in para 2g above) have a detrimental impact on the delivery of other services.

Learning.

Whilst identifying its findings and recommendations into the adopt / adapt / abandon categories below, Clinical Senate agreed although clearly many changes were implemented and working well, it did not have background information to understand what were the elements that enabled the implementation of successful change or indeed resulted in changes not being effective or beneficial.

Clinical Senate recommended that in order to spread learning and facilitate future change and transformation in service delivery across the East of England health and care system, a valuable exercise would be **to look at why what worked did work and why what didn't work didn't**.

Adopt: retain and adopt this practice

a) **Increased focus on infection prevention and control** across primary and secondary care, social and community care settings.

b) Continue with the protected or **'Green'** (non-COVID-19) **elective facilities** within sites, providing protected elective facilities and pathways.

c) **Pandemic and emergency planning**. Increase the profile of the respective Emergency Preparedness, Resilience and Response (EPRR) teams; develop shared learning and support mechanisms and clarity around the role and authority of the respective EPRR teams. Ensure that learning is shared between teams. Ensure that as a system a more seamless and consistent approach and messaging can be delivered in future.

d) **Remote tele-consultation**. Tele-consultations should be encouraged, supported by improved patient record sharing, multi-agency and inter-agency working (e.g. across

social care, health, police, acute, mental health, community, primary care networks). This has the ability to offer a much more convenient service for many patients with the additional benefits to the environment in terms of carbon footprint and in terms of the requirement for expensive healthcare facilities and estates. Flexibility may enable more staff to offer out of hours appointments and weekend working with a move towards better seven-day provision. We must ensure that such a change does not disadvantage particular patient populations and we must work to consider appropriate solutions to those who do not have access to modern information technology.

e) **Timely adoption of innovation.** Removal of duplicated and / or unnecessary formal governance processes, adopting a 'can do' approach.

f) **Proactive patient care:** multi-disciplinary approach to 'cold calling' the most vulnerable, sharing of patient records, social prescribing, routine use of frailty scores, advanced care planning and treatment escalation plans for all patients in the last years of life including training and use of the ReSPECT[3] process. Understanding and addressing the mental health needs of individuals as well as addressing their physical care.

g) Wider and easier access to, and better use, of real time **activity data**.

h) Recognising the importance of the support we need to ensure the **health and well-being of our staff,** including psychological support and that the provision is over and above a standard occupational health service. We need to ensure that organisations train their managers to help support staff well-being through compassionate leadership. We need to be able to provide more support to those staff wishing to address modifiable risk factors such as smoking and obesity.

[3] https://www.resus.org.uk/sites/default/files/2020-06/COVID%20ReSPECT%20Guidance%2023042020_0.pdf

Adapt: practice should be retained subject to some further development or refinement

a) Empowering health and care professionals to reduce the 'over medicalisation' of care, particularly for the frail elderly, and to understand what the ideal level of care is for the individual.

b) The use of sophisticated methods for prioritisation of care, enabling treatment to be delivered on a priority of need basis rather than a time on a waiting list basis. We need to reconsider the effectiveness of current referral pathways and refine them where necessary to deliver the best outcomes for our population.

c) The above covers all conditions but in particular to support the management of early stage diagnosis in cancer.

d) There needs to be an improved supply chain particularly for items that would be in large demand such as PPE, other equipment (e.g. ventilators), medicines. The issue of limited maximal hospital oxygen supply needs to be resolved to prepare for a second wave or future pandemic.

e) Continuous training for all clinical and non-clinical staff on the use of technologies and how to employ full functionality to support the delivery of care. Workforce strategies that support the (speedy) implementation of innovation and technologies to ensure safe and appropriate delivery of treatment and care. We must not lose the innovations already made on the culture of willingness to innovate.

f) Continued use of tele-conferencing for multi-disciplinary meetings, training, education, management meetings, recruitment etc is to be encouraged.

g) Increased role of occupational health to support staff risk assessments and health and well-being.

h) There should be wider and easier access to, and better use, of real time activity data.

Abandon this practice.

a) The assumption by professionals and the public that 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)' means “not for treatment”. There should be a lot more work to develop a dialogue that clearly describes the appropriate level of care with full implementation of the ReSPECT process.

b) Fear by GPs that they will not examine patients before transfer to hospital. The Clinical Senate recognised that it was hard to know how widespread this problem was, but Senate Council members were aware of quite a lot of anecdote.

c) Public fear that attending any healthcare facility had a high risk of resulting in infection, leading to many patients not attending for important diagnostic tests or treatment including those on cancer pathways. We must ensure that a strong message regarding the safety of protected diagnostic and elective pathways is communicated to the public to avoid unnecessary delays and missed diagnoses or treatments.

d) Complete separation of frail elderly and other shielded groups from significant others - we need a risk analysis tool for patients, professionals, and families/others. We need to consider how we can support these vulnerable individuals better in a future pandemic.

e) An assumption that health care needs should be the sole decision criteria moving forward.

f) The resumption of organisational boundaries, silo working and competitive commissioning.

g) Reactive panic responses and confusing messages / guidelines that change too often and without much evidence.

h) Prioritising one emergency demand above preventative and elective interventions.

i) Meetings that have no clear intended outcome or purpose.

Recommendations

1. **Workforce**
   a. We must ensure that all organisations have a greater focus on the health and well-being of their staff. This should include training managers to adopt a compassionate leadership style, encouraging healthier lifestyles including, for example, cycle to work schemes, helping staff address modifiable risk factors and an increased focus on, and resource for, occupational health services. We must continue to increase awareness of mental health and well-being amongst staff including offering more resources and training managers in recognising and supporting those with mental health issues. We must ensure that at risk groups such as those from a BAME background or with underlying health conditions have appropriate support and the risks related to COVID-19 and / or other pandemics are appropriately mitigated.

   b. We must work towards a more standardised approach to training, competencies, recruitment processes, occupational health assessment and other human resource factors to enable more seamless movement of staff across organisations at least within each STP/ICS.

   c. We must encourage, support and train our staff to adopt innovations to improve the outcomes and experience of our staff and population.

2. **Diagnostics**
   a. We must ensure that we have adequate molecular diagnostic pathology services to ensure sufficient capacity to deliver timely results that, through information technology systems, are accessible across all relevant health and care settings.

   b. We must ensure that we have adequate diagnostic capacity, including radiological and endoscopic facilities, that is designed to deliver services for patients affected by infectious diseases during pandemics and for protected facilities for those with other conditions. Our facilities and processes should allow for infection prevention and control measures including social distancing and adequate and appropriate air exchange systems.

3. **Patient Experience**
    a. We must adopt and refine tele-clinics to ensure that they offer the best possible experience, convenience and outcomes for patients.

    b. We must ensure that we adequately support those who have to shield or those that have significant visitor restrictions during future pandemics or second waves.

    c. We must ensure that we provide appropriate and honest reassurance regarding the safety of our diagnostic and therapeutic pathways to prevent poor outcomes for patients.

4. **Innovation**
    a. We must continue to encourage a culture willing to innovate as demonstrated during the pandemic.

    b. We must ensure that we appropriately engage with our staff and patients to ensure that they understand the new pathways and that our staff are appropriately trained.

    c. We must ensure adequate resources for digital services to support innovation.

5. **Protected Elected Pathways**
    a. The need for protected elective pathways and services has been further emphasised by the pandemic. All STP and ICS's must ensure that they rapidly work towards ensuring they have adequate protected elective capacity to meet future needs.

6. **Culture**
    a. We need to capitalise on the culture of innovation and collaboration to ensure that the momentum achieved during the pandemic and potential long-term benefits are not lost.

7. **Emergency Response**
    a. The NHS must reflect and learn from its emergency response to the pandemic. We must ensure that going forward we can:
        i. Deliver clear, consistent, unified and evidence-based messages and guidance
        ii. Have robust supply lines of all key, high demand PPE and a robust high-volume oxygen supply in all relevant secondary and tertiary care centres
        iii. Provide appropriate support and guidance to social care organisations and services in a similar way as to those within the NHS.

8. Infection Prevention and Control

a. We must ensure that infection prevention and control training and preparation is optimised in all relevant organisations including those in social care and other health care settings (e.g. dental, ophthalmology) as well as secondary and primary care.

9. Pathology:

a. Clinical Senate recommended that a review of provision of pathology facilities and capacity across the East of England be undertaken as a priority, with a view identifying the current provision and the potential investment required to have up-to-date equipment, provision and systems in place to best serve the population of East of England. The system needs to ensure that it has the capacity for high volumes of tests as well as the ability to process results and communicate them in a timely manner.

End.

Glossary of abbreviations

BAME	Black, Asian & Minority Ethnic (group)
EPRR	Emergency Preparedness, Resilience and Response
ESNEFT	East Suffolk & North Essex NHS Foundation Trust
STP / ICS	Sustainability & Transformation Partnership / Integrated Care System
NICE	National Institute for Health and Care Excellence
PPE	Personal Protective Equipment
WFH	Work from home