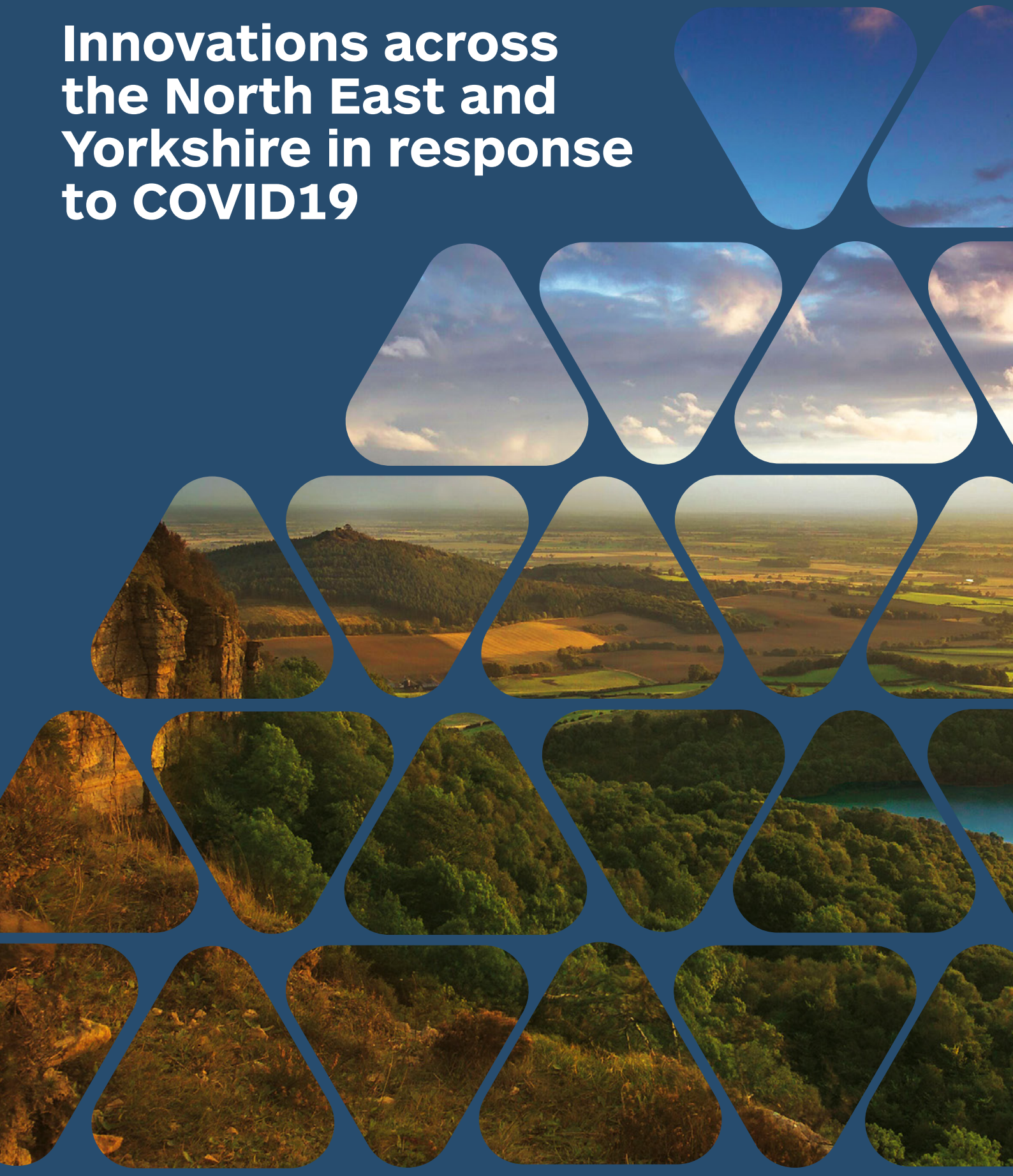
Innovations across the North East and Yorkshire in response to COVID19



Yorkshire & Humber AHSN

Academic Health Science Network
North East and North Cumbria

Introduction

Working in partnership with North East and North Cumbria Academic Health Science Network (NENC AHSN), the Yorkshire & Humber Academic Health Science Network (Yorkshire & Humber AHSN) conducted a series of Rapid Insights reports across the North East and Yorkshire to understand how the pandemic was impacting on staff, patients and organisations in the region.

As part of this work, case studies were conducted with key stakeholders to evidence examples of best practice and innovative solutions to common problems.

The case studies were collected from the four Integrated Care Systems (ICSs) in the North East and Yorkshire region: Humber, Coast & Vale Health and Care Partnership, West Yorkshire & Harrogate Health Care Partnership, South Yorkshire & Bassetlaw Integrated Care System and North East North Cumbria ICS. The case studies formed part of the individual ICS reports that have now been published.

This document presents a compilation of all the case studies that were documented from across the North East and Yorkshire between June and September 2020. They represent an array of examples of innovative responses that were made to ensure that services were continued during the pandemic. They include changes initiated and implemented in primary care, secondary care, local government, care homes and ambulance services. They embrace changes in technology, workforce, leadership and partnership working. The specific areas of focus include the elderly and the vulnerable, mental health, dentistry, hospital discharge, rehabilitation and maternity services.

All the changes were made at pace and with the aim of providing the best patient care despite the unprecedented challenges health and care staff had to face. A number of these changes have now been implemented permanently and have become business as usual.

The interviews were conducted by members of staff from the Yorkshire & Humber AHSN on Microsoft Teams and recorded for notetaking purposes. Each one has been approved by the participants involved. We are very grateful for the time given by the contributors to share their experiences with us.

Understanding how COVID-19 has changed our health and care system:

The numbers behind the rapid insights work across the North East and Yorkshire

471 responses to four rapid insights surveys

509 responses to the Digital Primary Care survey

Contributors include:

CEOs, Directors, Managers, Doctors, Nurses, clinical staff and non-clinical staff

From:

ICSs, CCGs, Acute Trusts, GP Practices, Mental Health Trusts, Community Trusts, Ambulance Trusts, Care Homes, Local Authorities and 3rd/ Voluntary Sector

Patients and the public contributed to research from

76 public engagement organisations and patient advocate groups

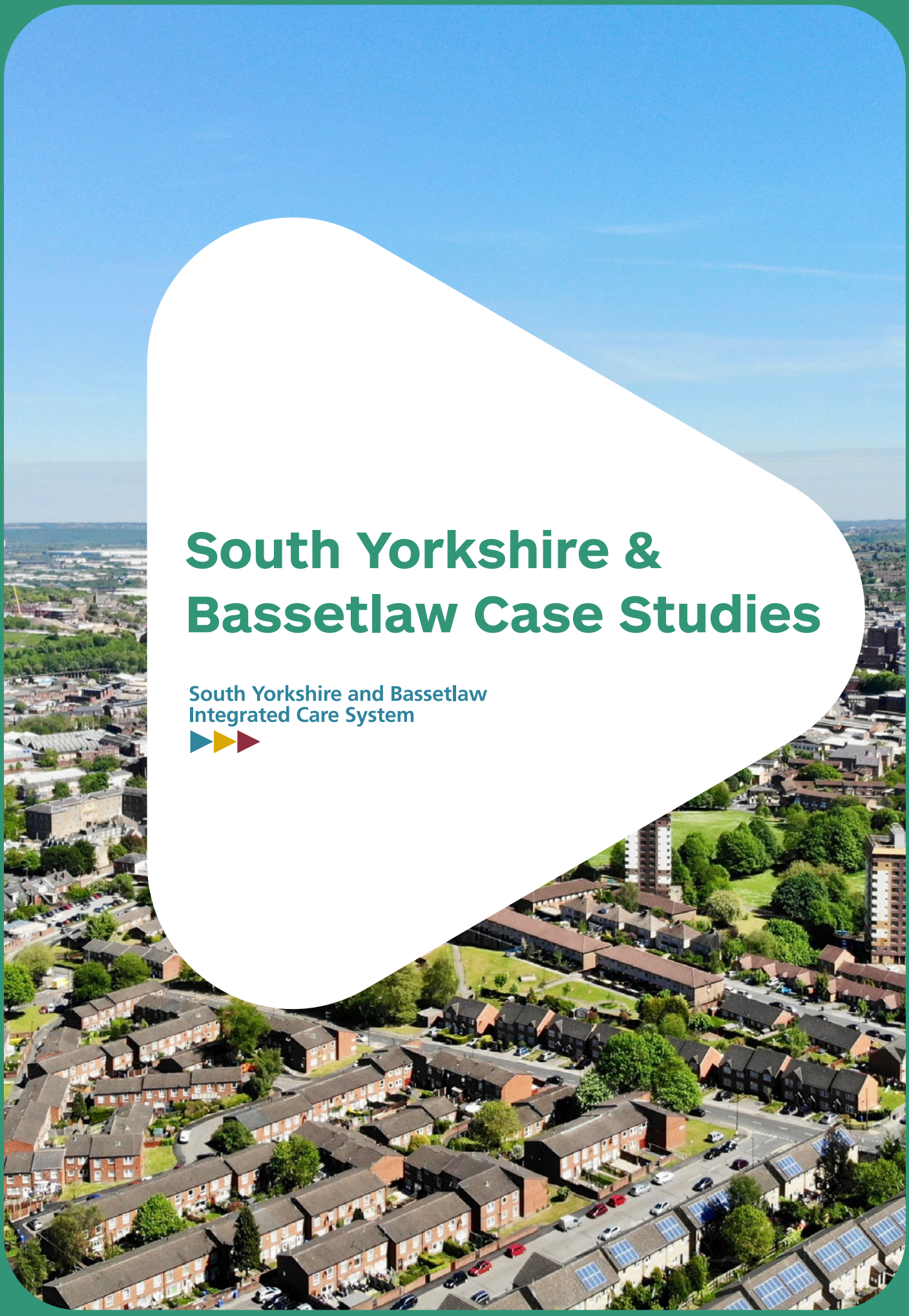
54 hours of dedicated interviews conducted to create:

- **34** case studies
- **47** facilitated discussions/ workshops

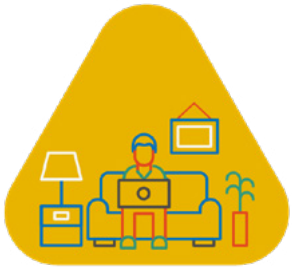
Contents

South Yorkshire & Bassetlaw Case Studies

South Yorkshire and Bassetlaw
Integrated Care System



Technology and Remote Working



Stroke services rely heavily on face-to-face patient assessments but found new ways to provide quality treatment to patients in vulnerable situations through remote provision of care.

Approach/Methodology

Launched in January 2020, the SYB Stroke Hosted Network's response to the pandemic involved bringing together services and staff (managers, clinicians and leaders) from across the system to make tangible plans to ensure stroke services were able to continue. This included responding to NHS England guidance on how to adapt stroke services during the COVID-19 incident.

Three areas of SYB's stroke services that encountered rapid adaptions included:

- Transient Ischaemic Attack (TIA) clinics – an urgent outpatient pathway which usually offers face-to-face assessments moved to telephone and video consultations for triage. This ensured that only those who really needed face-to-face TIA assessment and investigations attended a clinic.
- Stroke Review Clinic for six-week reviews (post-stroke) – this moved from an initial hospital setting to a remote one using telephone and video consultations. Clinicians who were self-isolating were still able to provide care.
- Community rehabilitation services adapted to reduce face-to-face contacts (alongside telephone and video conferencing solutions) and to provide remote rehabilitation.

Impact

In some places within SYB, TIA and stroke clinics were relocated and a 'one stop' approach was used to reduce patient movement through hospitals. Clinicians were able to provide remote consultation, triage patients and continue to provide vital services. Community-based stroke services began to offer rehabilitation using remote technology, which ensured that patients continued to receive the support, guidance and rehabilitation they needed.

Feedback from clinicians was positive, expressing that they were willing to adopt the new approaches. However, it was also acknowledged that remote consultation and rehabilitation is not a solution for all; some patients require face-to-face (physical) assessments and rehabilitation.

The Stroke Hosted Network was able to quickly share learning across the system - and beyond - through webinars and workshops. Through video platforms

such as Zoom and Microsoft Teams, the first webinar on remote technology was delivered in partnership with AccuRx. The session had over 100 attendees from across the country. The second webinar, which focused on the evidence base for remote technology in rehabilitation, had approximately 300 attendees. It is clear that the high number of attendees and participations may not have been achieved under normal pre-pandemic circumstances.

The learning shared included the practical uses of remote technology within the stroke pathway, how it could benefit patients for rehabilitation, the available evidence, new research and the need for further research into using technology to support patients. Regional workshops then gathered learning from clinicians across the region about the adaptations made to stroke services in response to COVID-19.

Next Steps

Learning from the rapid response to COVID-19 has been used to develop new areas within the Stroke Hosted Network. The success of using remote technology to complement the stroke pathway has led to further prioritisation of digital innovation within the work programme.

Further research, and linking into the digital transformation programme, will be required. This should include further exploration into both the benefits and limitations of remote technology across the stroke pathway which would be additionally helpful.

Clinicians and patients would benefit from more training and education on how to use remote technology to support consultations and rehabilitation. The Network has been talking to patients to gain further insight of experiencing a stroke during the outbreak of COVID-19.

Key Learning Points

In response to COVID-19, the national guidance was useful in supporting the region to adapt. This needed further application within a regional context - and within the network services - to explain how problem solving and adaptation took place across the system.

Organisations had to make several adjustments to meet the needs of their patients and services. This inevitably led to some minor variation across the region, but the guidance and network supported consistency where possible.

The Stroke Network enabled all partners to work collaboratively and the rapid introduction of remote technology enabled stroke and TIA services to continue during the peak of COVID-19. Rapid insights and learning was shared using remote technology as a result of this. Although the use of remote technology can complement the stroke pathway it cannot fully replace face-to-face, 'hands-on' assessment and rehabilitation.

Testimonial

"Everything that we try to do, and every adaptation that we make, has patients at the centre of it. We've always considered how we could provide the best quality service to our patients and their families, how we could support patients with stroke care during this really critical time, given what was happening across the world with COVID-19."

SYB Stroke Hosted Network Manager

Interviewee: Jaimie Shepherd, Network Manager, SYB Stroke Hosted Network.

The Network is hosted by Sheffield Teaching Hospital NHS Foundation Trust and supported by SYB ICS.

Partnership Working for the Shielded Population in Barnsley

Early in the COVID-19 pandemic, Barnsley Council identified vulnerable individuals in the local population using data from various sources including the electoral roll, adult social care, Yorkshire Water, energy companies and other companies who may have a flag that determines social, economic, physical, mental health vulnerabilities.

Approach/Methodology

A Vulnerability Index was formed and a strand of this was the shielded population. This identified roughly 60,000 households that had one or more vulnerabilities and were categorised by priority. The contact centre wrote to all those households to inform them of available support. In addition, they called 10,000 of the most vulnerable, resulting in hundreds taking up additional support which they might not have otherwise received.

The Shielded Patient List (SPL) identified vulnerable patients thought to be at high risk of complications from COVID-19. They were advised what shielding meant, how to do it and how to access support. Care plans were reassessed and advice on how to access appropriate services was given to minimise the risk of infection exposure.

Impact

The households taking up additional support, including access to essential supplies, is the key message in terms of impact of the programme, as the outbound calling proved effective and was appreciated by the recipients.

The shielded patient programme finished at the end of July 2020, as did proactive outbound work in the contact centre. The Vulnerability Index from a patient perspective had positive feedback as they appreciated being contacted, even if they did not need anything. For many who were unable to leave the house or did not see family as much, it was a welcome form of communication to break up the isolation.

The Intelligence Cell has been a positive development in understanding the data and provides a system view of what is happening, giving equal weighting to areas of the system that are not as well understood or prioritised in the way they should be.

Next Steps

1. The Clinical Commissioning Group (CCG) will be looking at development around use cases which need a lot more engagement from clinicians in the NHS, CCG and wider organisations who need to understand how to use this information in different ways to improve health outcomes in Barnsley. User engagement/ research is necessary.
2. Revision of the current index from being context-specific to considering other data sets that could strengthen and improve the index.
3. The Information Governance (IG) component: what is feasible for an IG that can determine differentiation in data sets?
4. People engagement, how their information is used and highlighting these concerns.

Key Learning Points

Inconsistencies in how advice was given was noted, as many people were unaware that they were on the shielding patient list, as well as mixed messages from hospitals and GPs. In the event of a resurgence of cases in Barnsley, a local plan would involve better preparation and avoidance of past errors.

Interviewee: Joe Minton, NHS Barnsley Clinical Commissioning Group.

Changes to the Emergency Department

Steps were put in place to reduce footfall through the Emergency Department (ED) in The Rotherham Hospital NHS Foundation Trust (RHFT), whilst still providing people with the necessary care and advice dependant on their presentation to ED.

Approach/Methodology

RHFT has an urgent and emergency care centre which integrates the ED with a walk-in centre. A clinician, such as a GP, would then screen everyone at the door to assess whether admittance to ED was the most appropriate action. Signposting to other services, such as pharmacies for advice and self-care at home, was also provided.

It became clear that to reduce footfall in ED, the layout of the area had to be amended. As part of important adjustments to ensure stringent infection control measures, the hospital had to ensure the separation of patients presenting with potential respiratory issues from others who may pose a risk due to their condition. The Orthopaedic Department, located next to the ED, was treating minor injuries. Orthopaedic services were also stopped as it had a separate entranceway and this reduced the number of people entering ED. Similarly, appropriate paediatric cases were triaged to ensure they were directed to the Paediatric Ward as appropriate.

Impact

At the peak of COVID-19, the hospital saw a 50% reduction in ED attendances. Staffed by clinicians and GPs, the triage system in ED ensured that visitors to the department were appropriately assessed and cases managed based on clinical need. For visitors not admitted to ED, other resolutions involved signposting as appropriate to other wards, health services or suitably resolved without further need for clinical intervention.

Feedback about the triage system proved valuable and has been well received by the public. Visitors that were asked to participate in the survey were satisfied that they had consulted a clinical professional and received appropriate support.

The suspension of some services, such as elective surgery, also enabled the expansion of additional facilities to support social distancing and separation of respiratory (and non-respiratory) patients. The reallocation of staff, who would otherwise have been working on these closed wards, supported this infection control activity.

With services restarting, there are ongoing challenges to manage the hospital site to maintain safe distancing, but this is carefully resolved through stringent infection control processes.

Next Steps

In the SYB ICS, the Urgent and Emergency Care Network (UEC) are exploring how some of the changes made across ED departments can be embedded across the system, including minor injuries. Business cases are being considered and put forward, yet workforce and estates considerations are potentially limiting factors when considered in the round.

The UEC group and Yorkshire Ambulance Service are looking to have clinical access provided via ambulatory care. This will enable healthcare workers to assess patients and make recommendations for alternatives to ED, or provide relevant care to remove ED as a step entirely.

Key Learning Points

The use of clinicians to triage at the door has been well received by the public and enabled the reduction of footfall into ED.

It is important to get all stakeholders in a patient pathway on board to ensure champions of the change throughout and reduce challenge.

Strong business cases include workforce considerations, estates and the associated costs. By not considering these, it can be challenging for people to remain positive when things start to fall over. Robust plans are needed to address teething issues and mitigate risks early.

Interviewee: Dr Kay Stenton, The Rotherham NHS Foundation Trust.

The Development of a Palliative Care Ward in The Rotherham NHS Foundation Trust

COVID-19 was expected to put overwhelming pressures on Intensive Therapy Units (ITU). However, many patients did not go to ITU wards but instead needed palliative care support – but there was insufficient capacity.

Approach/Methodology

Palliative Care is not usually thought of with an urgent context, but when the hospital recognised that palliative care space was going to become an issue it took a new proposal to senior leaders – converting a ward into a Palliative Care space.

As the pandemic started to intensify and patient numbers increased across Rotherham, the hospital reconfigured a ward to provide palliative care. Supported by the matron within Care of the Elderly, the team quickly turned one of their existing non-urgent care wards into a dedicated ward to provide care for palliative care patients.

The converted ward was busier than had been anticipated, and used more frequently than ITU. Sadly, over 100 deaths were recorded across a two month period. Despite the sad circumstances leading to its formation, the Palliative Care Ward was well-staffed and nurses were redeployed to the ward as required, ensuring high-quality and sensitive end-of-life care was given to patients.

Impact

Initially, some staff felt concerned about the possible risk of infection. Following dedicated training sessions (two per day) staff allocated to the ward were suitably reassured about stringent infection control measures and upskilled as necessary to work in this temporary palliative care setting. Nursing staff also found that they had more time to nurse patients and deliver high-quality personalised care. This was especially important at time of restricted visitor access for relatives and friends.

One of the key challenges was keeping families in touch with patients. With visitations prohibited, staff provided opportunities for video and phone calls (between relatives and patients) to keep families in contact.

The interviewee is a consultant working predominately in the community with day-to-day dealings with the hospital. As visitations were heavily reduced, our interviewee and their clinical team were able to support in the palliative care ward

instead. During the height of the pandemic the team was able to support with ward rounds, freeing up hospital consultants for more urgent care.

The enhanced visibility of the Palliative Care Team within the hospital has been a catalyst for change within the hospital, helping to support continuous improvement. For example, the Accident and Emergency Department, which would typically be the first point of contact for patients, was then able to triage accordingly - and refer directly to the Palliative Care ward.

Palliative care now has far greater visibility in the hospital with an improved focus of its significance across the organisation.

Next Steps

Given the increasing pressures on ward space, this temporary ward for palliative care was closed and reverted back to an acute setting.

However, the trial has instigated an important conversation about the importance of palliative care and the use of wards, with an improved awareness of the needs of patients during all parts of their hospital care.

Key Learning Points

There appears to be an opportunity to enhance the palliative care pathway through a joined-up approach that supports acute and community care. Our case study suggests that there may be ways of keeping palliative care patients out of hospital through more dedicated ward space and bypassing Accident and Emergency where clinically appropriate.

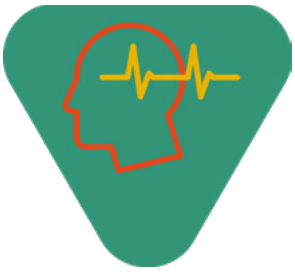
The benefits of changing the triage model for eventual palliative care patients offered a number of benefits including better patient experience, reduced waiting times, reduced pressures on the Emergency Department and a reduction in clinical interventions – equating to a financial saving that can reinvested into other areas of the hospital.

There has been enormous recognition of the work across palliative care in which the team, temporarily assigned to provide a critical response, delivered a high-quality service during a pandemic.

A business case is now being developed to support this adaption as a permanent measure in the hospital.

Interviewee: Fiona Hendry, Consultant in Palliative Care, Rotherham NHS Foundation Trust.

Remote Patient Assessment and Changes to Medication Protocols in Mental Health Settings



Mental health assessments are a critical and complex area for mental health and social care trusts as they adhere to national health and care policies and regulations, including the Mental Health Act (1983) and the Mental Capacity Act (2005).

The Mental Health Act has a Code of Practice, which is statutory guidance, and provides a robust framework for mental health assessors and practitioners, enabling healthcare professionals to interpret the guidelines in day-to-day practice. The Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) had to ensure their sound interpretation of the statutory guidance, alongside other sources of guidance, to arrange a legal, safe and appropriate way of assessing patients; this was at a time when face-to-face assessments were considered to pose a high (COVID-19) infection risk.

The complexity of delivering virtual assessments is not to be underestimated; these sessions are habitually completed face-to-face, with another professional present (e.g. social worker) and adhering to strict administrative procedures (such as the signing of patient forms) – typically done in-person. As a result of these complexities, remote assessments were considered to be highly challenging prior to COVID-19.

This is because of the intricacies of legislation, drug prescriptions and medications being strictly controlled.

During the pandemic, there also were reported shortages for end-of-life medications, which could potentially lead to patients being in pain during their final hours – this was obviously both unethical and unacceptable. Furthermore, healthcare practitioners were sometimes unable to enter a patient's home due to social distancing measures, preventing the safe administering of medication. There was therefore an urgent need to see if practitioners could adapt to the legislation and infection control restrictions, to oversee the treatment process - without compromising the clinical quality for staff or patients.

Approach/Methodology

Mental Health Patient Assessment

The team included a Consultant Psychiatrist, a Social Worker from the Local Authority and a Mental Health Act Manager. In the early stages of the lockdown, this team examined all the legislation, case law (such as The Human Rights Act, 1998) and other relevant polices and legal guidance. The team sought legal advice and were able to use a previous case study example supplied by the Local Authority which they could draw as a basis with which to follow safely in these new, unprecedented circumstances. Together, this team devised a ten-page document within one week, to ensure that they could safely resume mental health assessments in a legally compliant and patient-centred manner.

This particular case study focuses on how one member of staff, shielding due to COVID-19, could continue working in a safe, secure way. It provided an opportunity for the Trust to demonstrate how it could innovate and ensure equality for staff to safely continue working where safe adaptions to assessment protocols were possible.

This document enabled the team to stipulate clear guidelines including key safeguarding measures but also practical elements, such as the adaptions for patients authorising consent (or signing off) documents electronically. These swift, practical measures reduced the threat of infection by ensuring that social workers only needed to deliver documents digitally to the hospital (but not in a physical capacity).

Changes to Medication Protocols

As part of routine care of a deceased patient, it is standard practice to retain unopened medications rather than needlessly dispose of them. In order to carry on with this important aspect of their duties, social workers were able to continue working with the hospital by following enhanced health and safety infection control measures.

Similarly, safety protocols were also put in place for patients to continue self-administration of (certain) medications, with a necessary relaxing to ensure treatment was still being delivered as needed. In this case, self-administration was only permitted when it was absolutely safe to do so, training patients or a trusted family member to assume these roles remotely on the practitioner's behalf.

Thanks to the Chief Pharmacist, strict protocols were outlined for the healthcare workers to follow. This enabled the hospital and its practitioners to continue delivering their assessments, gaining the necessary approval of COVID-19 Gold Command in the Trust.

Impact

Mental Health Patient Assessment

The Chief Pharmacist's protocols document was presented to the COVID-19 Gold Command, enabling swift local use across Doncaster. It was also able to be used across neighbouring areas in Rotherham and North Lincolnshire.

By ensuring mental health assessments were able to continue throughout the pandemic, practitioners were able to utilise technology (such as Microsoft Teams) where otherwise these appointments might not have been possible.

National guidance, which has since been released, mirrors what has been produced locally. NOTE: this was incidental and did not involve discussions with Doncaster or the Trust).

In terms of patient feedback, the response to virtual assessments was varied, but did offer patients more choice by continuing to provide face-to-face assessments alongside these new virtual consultations.

Changes to Medication Protocols

During this adaption, patients were able to self-administer their medication in a safe way, allowing for the safe continuation of treatment.

Next Steps

Mental Health Patient Assessment

These remote mental health assessments are now subject to Government review. It is likely that these adaptations will only be used within the duration of the pandemic, but gives scope for the Trust to consider in future.

Changes to Medication Protocols

Whilst the temporary measures taken for administering medication have enabled important treatments to continue, it is likely that the Trust will revert back to pre-pandemic processes from a risk-benefit point of view.

Key Learning Points

With the service disruptions and risk-to-patients caused directly (and indirectly) by COVID-19, the innovation that enabled mental health assessments to continue has been highly positive and motivational.

Rapid change can often galvanise and energise teams to pull together to achieve more (as evidenced here). However, there is still a balance between working at rapid-pace and ensuring patient safety.

In times such as these, NHS structures and governance can inadvertently create unhelpful 'barriers', which can then sometimes come at the expense of innovation or making logical changes quickly.

There is a concern that barriers will re-emerge once the pandemic is under control. In order to capture the creativity, originality and invention within experienced teams, we need to consider how remote working might support the NHS going forward – celebrating the effectiveness that has clearly been seen during gold command stages of the pandemic.

During this time, the offer of remote working was valuable. The team has a large number of Black and Ethnic Minority (BAME) staff, who knew that they were disproportionately at risk of contracting COVID-19 alongside vulnerable staff groups such as those in pregnancy. Remote working options gave our team reassurance that risks to staff were being acknowledged (and reduced), which supported our shielding staff member to continue supporting the team, their patients and our wider organisation at place.

Remote meetings between staff have been a huge positive, increasing system working and improving efficiencies related to time-savings and cost of travel.

Ordinarily, it is best practice to use new medications rather than reuse an already-dispensed supply (such as those previously prescribed for another person). However, it is a valuable back-up option should medication supply lines be adversely affected by Brexit or COVID-19 (or other Coronaviruses) in the future.

Overall, our team have learnt an awful lot, and we're grateful to have been able to maintain delivering mental health assessments in a safe and caring way.

Interviewee: Navjot Ahluwalia, Executive Medical Director, Consultant Psychiatrist in Substance Misuse and Director of Research, RDaSH.

Adult Speech and Language Therapy, The Rotherham NHS Foundation Trust

The majority of the Adult Speech and Language Therapy team's work for The Rotherham NHS Foundation Trust's (TRFT) is delivered face-to–face due to the vulnerability and frailty of the patient cohorts. This includes neck cancer patients, the elderly and complex-need patients with neurological conditions.

Our team initially found it difficult to plan and prioritise in those uncertain first few weeks of the pandemic; this was because many staff thought they might be redeployed and moved across the Trust to other areas of high-need. One of our concerns was over the mandatory use of PPE, especially face masks, which obviously poses issues for our speech therapy work. With all outpatients' appointments and non-urgent community visits stopped, our most vulnerable patients would normally call into hospital, or a relative/carer would call in to visit them. This meant we needed to consider how we would adapt to these new infection control measures.

Approach/Methodology

The team had already piloted a qualitative research project 18 months previously to test the delivery of voice therapy remotely through Microsoft Teams. It was done as a proof of concept within the Trust and subsequently approved (by the Trust) to incorporate into our service delivery from January 2020. Health Informatics were also supporting the delivery. These prior checks and balances ensured that the transition to deliver patient care remotely was easier than it might have been if we had been at a new starting point.

Video calls were used extensively for triage and Multi-Disciplinary Team (MDT) consultations. Phone reviews were later introduced for those who had their regular therapy stopped abruptly. Voice exercises for patients to access online were uploaded to YouTube and text-based resources were adapted so they could be quickly retrieved from text messages, helping patients use them more easily.

The team also worked very closely with the Royal College of Speech and Language Therapists to produce risk assessments for video consultations. This is due to be published shortly.

Staff who were surveyed about using virtual appointments gave positive feedback, with some even commenting that they felt the intervention was as good as an in-person appointment.

Impact

Staff found that they had to become more proactive in supporting patients with assessments so this has meant additional – but effective – work to enhance their own understanding of the patient's needs.

Patients have valued the option of having virtual appointments, with many suggesting that an interim face-to-face session every six-to-eight weeks to support the effectiveness of the remote sessions would be useful going forward.

Families and carers were well supported in caring for end-of-life patients in care home settings, getting additional advice from our team as required.

We also found that patients took more ownership of their treatment, particularly in regards to voice exercises.

Next Steps

There are a number of learning outcomes to be shared with the ICS and system partners, for example, around rewriting telehealth guidelines.

Patient experiences continued to be collected in order to support ongoing learning and confidence moving forward.

One key area to address is the availability of technology as some patients with smartphones and portable devices found the screens too small to interact with comfortably.

During the pilot, there had been discussions about loaning of iPads in the same way as other communication aids. Talks are continuing to take place about making a room available external to the hospital, such as in a community health centre, for patients to loan a device more quickly.

In terms of training, some care homes will need more support to feel comfortable using technology to its full potential.

Key Learning Points

With pre-pandemic arrangements in place for the delivery of virtual consultations, it has been a relatively easy process to build on, and this example highlighted this once more.

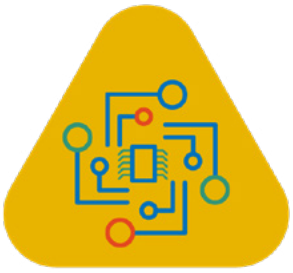
Confidence in technology can be an issue so ongoing support has been put in place to help staff and patients feel more comfortable using digital devices.

It's also important for our healthcare professionals to share good practice so that services, like ours, can continue to improve in how they integrate technology into their consultations.

I'm a keen advocate for a 'do everything you can' attitude to get changes to happen and be embedded quickly – it's important to try new things, learn from our experiences and share good practice.

Interviewees: Abigail Starr, Georgie Walker and Rachel Radford, Rotherham NHS Foundation Trust.

Digital Care Homes



Before COVID-19, there were gaps in Doncaster Clinical Commissioning Group's (CCG) understanding of the technological requirements across its local care homes.

Anecdotal evidence from primary care colleagues suggested there were limitations; care home staff were becoming increasingly reliant on their own personal smartphones to make video calls to health and care providers.

In April 2020, a Covid Care Home Action Plan for Doncaster was developed to ensure services provided a co-ordinated and effective response to keep residents safe. To minimise transmission they encouraged a virtual pathways 'by default' approach, ensuring that care could continue to be delivered remotely where safe and suitable to do so.

Approach/Methodology

A digital strategy for Doncaster was approved at the beginning of March 2020, yet there were no specific programmes planned in care homes.

COVID-19 enabled a quick re-prioritisation of some digital programmes. They focused on enabling safe, remote working across their organisations. They accelerated the roll out of video consultation tools, which had originally been planned for 2021. Early in the COVID-19 response, following National Health Service England (NHSE) guidance and as part of their Doncaster Covid Care Home Action Plan, Doncaster CCG took responsibility for delivering technology in care homes.

They conducted an IT survey to understand what digital capabilities care homes had. The results showed that most homes had access to PCs and laptops, but were largely without webcams, and equipment was generally only available to designated staff. Whilst most care homes reported having internet connectivity, it was intermittent and there was never full coverage.

In April, a national programme led by NHSE and Improvement to supply hardware to care homes was also initiated. However, given the fact that the needs were immediate (and the allocations from the national allocation unclear), Doncaster CCG made the decision to fund the digitisation programme itself by distributing tablet computers (iPads) to all of its care homes.

In terms of the allocations, Doncaster CCG based their distributions on home size and resident occupancy, but also worked closely with partner organisations in the process.

Doncaster CCG also enhanced their ease of use for the care homes, setting devices up with the necessary apps and website bookmarks.

This personalised approach was a key aspect of the implementation phase, ensuring that staff would be encouraged to use the new iPads (rather than reverting back to their own smartphones), including technical support in the transition.

Impact

Doncaster CCG has received very positive feedback about iPad deployment, and care home staff as key stakeholders in their virtual locality Multi-Disciplinary Teams (MDTs).

Close working across partner organisations delivered important (virtual) care and support to homes in extremely short timescales. The configuration activity to ensure the devices were ready to use in care homes was a major part in its success.

Using existing relationships ensured care home staff had a named contact to guide them through any technical issues. In fact, they made good use of this offer and Doncaster CCG has always tried to be highly responsive to any issues reported.

Next Steps

Doncaster's partner organisations will seek to find similar opportunities to use digital technology in the future. There are opportunities to continue working closely with partners, such as through the appropriate sharing of care plans and templates across social, mental health community and primary care.

Developing the necessary protocols and service specifications for care homes will be considered in order to review and develop the governance model.

A major component of this work will be to ensure technology is used appropriately and decisions pertaining to patient safety and clinical rigour go through the correct authentication processes.

Feedback from locality meetings to identify where training is needed or (where the skills gaps are) is still taking place.

Key Learning Points

Doncaster CCG has taken steps to ensure that partner organisations, especially those in primary care and care homes, have been involved at every stage of this innovative scheme.

Taking a reflective approach and learning quickly from issues in real-time, has ensured the digitisation of care homes has been as effective as possible.

Having stakeholders from multiple care settings involved in the iPad configuration and MDT set-up provided new insights to help support other organisations in trying to embed technology into their work processes.

One of our key learning outcomes is being able to finely balance the immediate needs of local residents alongside national schemes and initiatives. Where conflicting timelines or funding gaps exist between local and national plans, it is important to look beyond these complex differences and find workable solutions.

A second key learning outcome was assigning time to speak with local stakeholders. Dedicating time to understand local requirements and potential barriers helps to ensure a smoother transition, ultimately leading to more successful outcomes.

Testimonial

The Doncaster CCG Communications Team developed a case study focusing on a care home manager, a resident and the resident's family about their experiences. It was encouraging to hear that access to the iPads and having virtual opportunities to chat with their family, prevented the resident from feeling lonely.

It is clear within primary care, and across partner organisations, colleagues are embracing the increased use of technology. One Primary Care Network Clinical Director said they now have a totally different mind-set to technology given its success during the pandemic. In fact, they even stated that they intend to champion the use of Microsoft Teams for more pathways.

Interviewee: Katie Dowson (Place and CCG Digital Director – Doncaster CCG).

Clean Digital Clinic and Telehealth

The position of Director of Recovery at Rotherham, Doncaster & South Humber NHS Foundation Trust (RDaSH) is a new temporary position created in order to focus on recovery, reset and transformation.

Approach/Methodology

It became clear very quickly that digital interaction could improve the resilience of services, providing a safer alternative to face-to-face care, whilst also preserving service delivery. Whilst the concept was clear, the implementation would be a challenge as the Trust was not 'digitally mature'. However, through the cross-working between informatics, IT and process improvement teams, a new way forward was forged which enabled the use of new IT platforms and technologies to meet the needs of our patients.

These new collaborative teams also supported staff to change traditional working practices. This was about being able to remain clinically engaged with patients for ongoing delivery of care.

Digital exclusion was also identified as a major factor and a potentially major barrier. For certain vulnerable groups it is important not to assume there is ready-access to equipment, technological skills or personal capability to engage in this way. Digital exclusion became a focal point and we explored potential solutions. This led to 'A Clean Digital Clinic' – setting up an isolated clinical space with a desk and tablet device.

Impact

The immediate impact was supporting ongoing care to those who:

- Had increased vulnerability where face-to-face interaction was not preferred or recommended.
- Did not have access to technologies to support digital engagement.
- Did not have skills to use technologies such as virtual platforms, nor support to do this.

Taking stock of these digital exclusions early on ensured that patient needs were clearly understood from the start.

Initial barriers were experienced, most notably a slower-than-expected uptake. Since then, through increased promotion and awareness of the initiative, ongoing testing and feedback, uptake is improving.

Formal evaluation is ongoing and aims to provide a full and thorough review at a later date.

Next Steps

Digital exclusion remains an ongoing area of priority with further solutions already under exploration, particularly as the "digital first" approach is one that will likely be sustained in the future.

A secondary solution is already under exploratory assessment; a system for loaning telehealth equipment to those who have IT knowledge, but no access to equipment. Assuming this provides positive potential and possibility, this is expected to be initiated during the autumn period.

Testimonial

The real test will be taking the collective learning from all across the health and care system, and transforming services to be more adaptive, responsive and digitally supported within and beyond the NHS. By utilising the 'Adopt and Adapt' methodology to drive change collectively, efficiently and consistently, we are in a position to make real and long-lasting change.

Wider Areas of Learning

The enhanced package of support made available for NHS staff throughout COVID-19 has included access to a suite of psychological and wellbeing resources (via Our NHS People), setting-up areas of brief respite ("wobble" rooms) in health settings and professional and managerial support channels.

There has been overwhelmingly positive feedback about the range of enhanced staff health and wellbeing provided by the NHS, which has been additionally strengthened by the generosity of public fundraising efforts.

Changes mobilised to respond to the national mandate around discharge made sure the NHS cared for as many people as possible in the community. This has been a core focus for many years, but action was accelerated in their pandemic response. More complex patients were supported in the community by home-based treatment and crisis support teams in mental health services; and rapid response teams in community services to mobilise the home first model of care.

Increasing care in the community was supported by the initial redeployment of staff to manage increased demand. Around 100 staff in total were redeployed at the peak of the initial pandemic surge. From a sustainability perspective, they want to use the learning seen from the pandemic and work with commissioners and partners to define what services should look like to deliver this ambition longer term. It is also critical to maintain this position culturally as the major incident catalyst starts to subside and with it the risk of shifting back to traditional ways of working.

Alongside the digital first approach, RDaSH significantly changed the way they work to fully mobilise agile working practice. The Trust was already well progressed in mobilising agile working across clinical community teams, however the degree to which this was stepped up and the scope of use across clinical and corporate teams was successfully extended. This has directly contributed to keeping staff safe, enabled engagement and support networks and supported new ways of working outside of traditional NHS sites. They expect that this may support a very different estates profile in the future.

They want to ensure that alternatives are available to respond to individual needs but this change is something the trust will be looking to maintain in the future, especially considering their extended carbon footprint.

Whilst remote working has not suited everyone, it has received mostly positive feedback from both staff and individuals using patient services.

A culture of innovation across all levels of the organisation has taken place at RDaSH and it's clear that enthusiasm for it to continue should be harnessed.

As seen across the NHS and the wider health and care environment, RDaSH's workforce responded to the situation as it changed (daily), and adapted to form new approaches, keeping the safety and needs of patients, and their families, at the centre throughout.

Interviewee: Sarah Bowman (Director of Recovery – RDaSH).

Technology and Electronic Prescribing in Barnsley

Since the beginning of the COVID-19 pandemic, the Outpatients Department at Barnsley Hospital NHS Foundation Trust (BHFT) has driven rapid progression in technology.

Digital initiatives that have been put in place to support staff include:

- Dual screens in all outpatient clinics
- Upgraded broadband connection
- Upgrade of the VMWare Horizon VDI (commercial desktop and app virtualisation product) environment
- Paper-free processes for phlebotomy
- Rapid implementation of accuRx (messaging service) and Microsoft Teams video meeting platform
- Development of an electronic prescribing platform.

The above adaptions were all completed while engaging in the implementation of a brand new Electronic Patient Record (EPR) system, Careflow (clinical communication platform formerly Medway), by System C, which went live in April 2020.

Approach/Methodology

As expected for a new clinical platform or system proposed for live deployment in a health setting, the new electronic prescribing platform at Barnsley Hospital has undergone multiple design and test cycles to ensure its performance safety, clinical effectiveness and technical functionality.

With a patient record system already in place, it was decided to re-engineer the platform (using the latest HTML5 programing architecture) which ensured additional functionality, synchronicity and longevity across these digital projects. The new design focused on distilling the workflow of a 'typical' outpatient consultation into separate areas of clinical activity.

A lot of work had already taken place to support the e-Prescribing platform within the new Patient Portal, particularly in adding enhanced layers of security to satisfy the legislative requirements for electronic prescribing.

The extra security was added to the system in the form of a virtual smartcard technology, provided by Isosec, the importance of which was heavily promoted during the pandemic, when there were concerns over frequent cyber threats.

When a clinician accesses the electronic prescribing platform, a correct password allows an authorisation process to take place – in real time – during which the NHS Spine is consulted to confirm the clinical role of the prescriber. If authorisation is granted, the prescriber may then access the system.

The actual form is simple in both design and concept, whereby basic demographic data is pre-populated on the form. The prescriber will then acknowledge the indication for the prescription, and then completes the prescription itself - defining the drug, dose, frequency and duration of treatment.

This form is then submitted to the Dispensary, which has a dashboard for monitoring incoming prescriptions. The pharmacists are presented with two options: to accept or reject the prescription. If a rejection notice is clicked, the pharmacist has to give a valid reason for the rejection (such as incorrect drug dose, possible drug interactions and stock issues). The prescriber is also able to review the rejected prescription, make the necessary changes and re-submit the form.

Impact

The development of the electronic prescribing platform required a close relationship between the development team, the Pharmacy department and clinical staff.

During the development phase, the Pharmacy Department raised concerns that the Isosec security solution did not meet the requirements for an advanced electronic signature. Without their consent, the project could not continue, and remains in a state of suspended animation, awaiting final authorisation to proceed.

Throughout, there were high levels of engagement with the Pharmacy Department, often enabled by Microsoft Teams; this business communication platform has been transformational for both clinical and non-clinical audiences at the hospital.

In fact, many Multi-Disciplinary Teams (MDTs) have transitioned to the platform for their ongoing clinical activities; X-ray, Inflammatory Bowel Disease and various cancers.

For this reason, Microsoft Teams has the performance and functionality to become the default MDT environment across the region.

AccuRx has an easy, intuitive and accessible web-based interface, making it the perfect medium for conducting video consultations with patients. It was particularly helpful in the Maternity Department, enabling pregnant mothers to remain at home rather than being asked into a hospital setting, especially during the initial COVID-19 lockdown period. Whilst other platforms were considered (such as Attend Anywhere), AccuRx seemed to be the best fit for the staff and patients.

Next Steps

Linking up and sharing our experiences with the digital workstream of the ICS has been positive. Giving interviews, such as this case study, is helping to share good practice, initiate collaboration among regional digital experts, and facilitate nuanced discussion about complex areas such as digital security and legal interpretation; being in a virtual space means you can be much more direct and available.

It is imperative to have a common, shared goal that is consistent with the strategic vision of the Trust in all things digital. On a regional level, the ICS has a vital role in ensuring that there are consistencies of approach across the digital landscape between Trusts in South Yorkshire and Bassetlaw.

Looking ahead, the generic document viewer that has been built into the Patient Portal (V2) will be replaced by the implementation of MediViewer, a state-of-the-art Electronic Document Management System (EDMS). Other post-EPR deployments over the next 12 to 18 months will include an Electronic Prescribing and Medicines Administration (EPMA) solution and a centralised electronic handover platform (Careflow Connect).

Key Learning Points

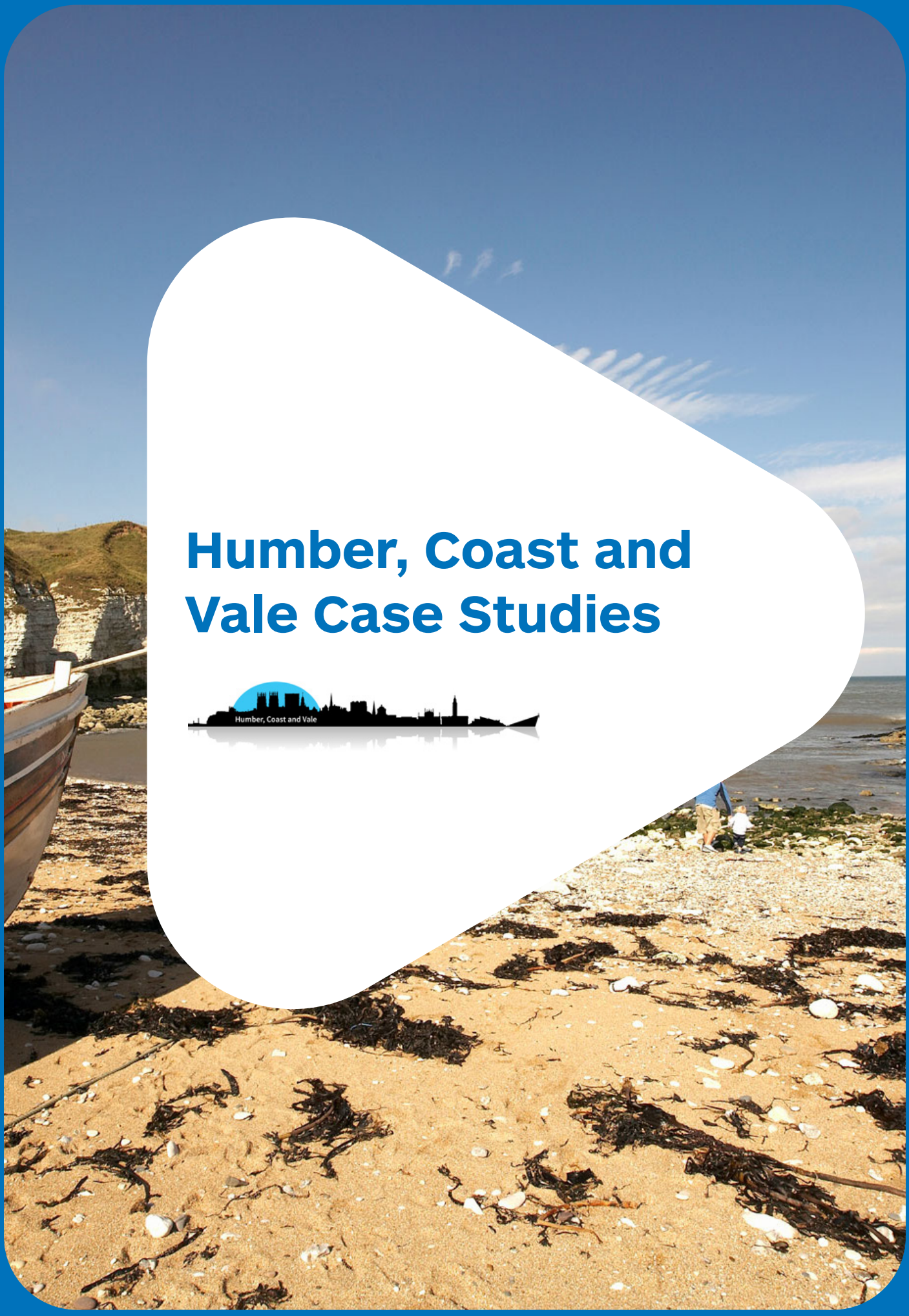
The level of legal and technical regulations connected to the use of advanced electronic signatures presents major barriers to implementation, bearing in mind that it is open to interpretation. Furthermore, there are considerable variances in practice across the region; in one area the use of a simple electronic prescribing transaction to take place between the host EPMA (Meditech) and Lloyds Pharmacy is permitted. This arrangement adheres to a level of technical and clinical assurance that is acceptable to the Pharmacy Department and the respective Trust.

If current paper-based prescribing systems continue to be used (with their inherent inefficiencies and inaccuracies) rather than the digital alternatives that have proven successful, there is a potential delay in the safety and expediency of delivering vital treatments to patients. This would be at a crucial time when it is needed most.

Overall, clinical engagement remains key to the development, implementation and rollout of any clinical platform.

Interviewee: Dominic Bullas, Chief Clinical Information Officer and Gastroenterologist, Barnsley Hospital NHS Foundation Trust.

Humber, Coast and Vale Case Studies



Primary Care Total Triage at Haxby Group

Haxby Group is a large multi-site GP organisation which works across York and Hull, with over 30,000 patients in each city. They were concerned about possible increases in demand for services due to COVID-19 and implemented a process to triage patients to manage this demand.

Approach/Methodology

As a partnership they agreed they wanted to go digital-first. The Engage Consult platform already procured and provided by the ICS was not one they found suited their needs, and since November 2019 they piloted, in two of their sites, a Finnish-based online consultation and triage system called Klinik Access. This system offers patients an online assessment using an artificial intelligence (AI) powered symptom checker.

The anticipated demands caused by COVID accelerated the roll out of the Klinik system from the planned 18 month/two-year timeframe to adoption by 11 sites in a few weeks. The Haxby Group were the first in the UK to adopt this system.

Impact

The Klinik system facilitates a total triage model, avoiding a first come first served approach with a system that is truly needs based. By using standardised systems, GPs could easily cover for colleagues working at different practices, which helped with the shortage of GPs in the Hull area.

Patients now have 24-hour access to their surgery. Health inequalities are not worsened due to lack of IT because the assessment outcome is the same for patients who use the system, call, or walk into the surgery.

Both Haxby and Klinik use a quality improvement methodology to enable rapid evaluation of change. For example, a COVID-19-specific triage algorithm was created in a few days at the start of lockdown.

Next Steps

34% of all queries currently come online, compared with 3% pre-COVID. The Haxby Group will continue to encourage patients to use the online platform to increase uptake.

The reduction in calls has freed up time for the admin staff and there are plans to train them to become care navigators.

A cost-benefit analysis will be undertaken by the Haxby Group.

Key Learning Points

Organise systems around people, not the other way round and when it is embedded into the organisation, structure the organisation around it.

A good communication strategy was essential for getting patients familiar with the change in process, as well as being upfront across the practices around challenges while adopting this innovation.

The relationship with the provider facilitated local solutions and local agility to meet the needs of their practice and the population.

Testimonials

"It is not enough to use the solution, you have to design the organisation around it and that is recognised by a lot of different providers, that you have to manage your urgent care in a certain way to maximise the number of people coming online."

Thomas Patel-Campbell,
GP Partner & CCIO, Haxby Group

Interviewees: Thomas Patel-Campbell and Prof. Michael Holmes, GP Partners at Haxby Group.

24/7 COVID-19 Mental Health Support in North East Lincolnshire (NEL)

NAViGO have been successfully operating a 24-hour Single Point of Access (SPA) telephone line for over 11 years, providing mental health support to people with higher level, complex issues above the age of 18. When COVID-19 hit, the service was further enhanced, expanding to cover all ages and offering a tiered model of tailored support for anyone affected by COVID-19.

Approach/Methodology

As of April 2020, the service expanded to incorporate a 24/7 COVID-19 support line to give access to mental health assistance to people affected by COVID-19. A multi-agency approach comprised of NAViGO, North East Lincolnshire Council (NELC), Rethink and Lincolnshire Partnership NHS Foundation Trust (LPFT) delivered the crisis support line which operated under a four-tier support model:

- Tier 1 is for those presenting with mild risk and needing low level support by SPA Advice Officers, who can offer self-help materials. This can include worries about risk of contagion from COVID-19, worry affecting sleep, stress from home working, amongst other lower level concerns.
- Tier 2 offers one-to-one virtual support as well as access to materials from tier 1, facilitated by NELC's wellbeing team. The types of issues are the same as those in Tier 1 but have been impacting the user for over two weeks.
- Tier 3 is supported by NAViGO's Access Team, which is comprised of the Crisis Home Treatment Team, Psychiatric Liaison Team, AMPH Team and Single Point of Access and requires a full CPA mental health assessment including risk assessment for those with clinically diagnosable mental health issues in need of treatment. This may require referral to Open Minds (local IAPT service), Community Mental Health Team or continue to be supported through Home Treatment provisions allowing for de-escalation back down tiers.
- Tier 4 is for specialist complex psychological support where the first three Tiers do not apply and there is evidence of trauma or where the individual has been through the Improving Access to Psychological Therapies (IAPT) services but needed more support/they were not appropriate due to the complexity of the issue.

Impact

The success of this service lies in the willingness of all the organisations involved to work in partnership and rapidly respond to local need, integrating teams to provide a comprehensive 24/7 service. Praise was given to the local CCG who allowed NAViGO and partners to co-produce the service. A lead commissioner also took part in some shifts as a clinician and conveyed how impressed they were at the speed the providers worked together to develop the service.

The ethos of this approach is to work from a consultative model, rather than treatment model, which recognises early signs and symptoms, perhaps of pre-trauma, mental distress or any other kind of psychological impact of COVID-19 there and then, without waiting until people may need a higher level of psychological services.

The service has also been essential for Key Workers, including fast track access to support, and the model has been further developed to support them, having a shop-floor presence within the local hospitals as an outreach element, allowing immediate face-to-face psychological first aid.

Next Steps

Taking into account that NELC regional concerns during the pandemic have been more on employment and social factors, rather than the national thought of increase in rates of COVID-19 and related deaths, the service is now looking to work with employment advisors and the department of work and pensions to respond to this need.

Development of a Mental Health Resilience Hub is progressing through conversations with wider partnership organisations across Humber Coast & Vale including exploration of a model that utilises the success of the 24/7 service as a foundation, focusing on building on the existing resilience of the population, identifying pre-trauma signs and symptoms and providing support through integration with existing local services.

Key Learning Points

The transition to an all-age service held some challenges due to some staff having minimal experience of dealing with children, young people or their parents for mental health needs, however the Young Minds Matter team have engaged in supervision and live advice when needed to support staff.

Work with existing partners and services, don't recreate the wheel.

Testimonials

"It is from a low-level perspective around bolstering that natural resilience... It is not about accessing secondary care mental health services but normalising the response to COVID-19 and giving confidence."

Head of Business Development, NAViGO

"All services had an initial lull at the beginning of COVID-19, when people were all staying home for various reasons. What we've definitely recognised is an increase in the need for access to support at the lower levels."

Clinical Lead for the Adult Crisis Home Treatment Team in Single Point of Access, NAViGO

Interviewees: Anna Morgan and Vicky Ayres, NAViGO.

Dental Pre-Appointment Communications in Hull

COVID-19 caused dental services in the UK to be suspended, apart from emergencies. The paediatric service at City Health Care Partnership (CHCP) was commissioned to see specialist referrals and referrals of vulnerable young patients, most of whom they had never seen before. This meant managing the anxiety of young patients who were unfamiliar with the dental team, who would also be wearing full PPE.

Approach/Methodology

The potential problem was discussed through the national network of the British Society of Paediatric Dentistry (BSPD). A staff member at Manchester Dental Hospital had previously developed social stories to help children's anxiety, which she was happy to share. The dental team at CHCP had used social stories before for patients with special needs, so the team adapted the resource for their practice to include photos of the staff with and without PPE, photos of the surgery and interactive activities for the children to do prior to their visit. In addition, they implemented a system whereby a dentist and dental nurse would meet the new patient in the car park to say hello before they entered the building.

Impact

Behavioural management, including the management of anxiety of patients, is now carried out prior to the appointment. Getting to know the child is done by telephone triage and followed up with the resource pack. Resources are either accessed online or posted out. This makes appointments more efficient and the time the patient is in the surgery is reduced. This therefore reduces the risk to both staff and patients.

The documentation has been shared within the organisation and Special Care Dentistry have already adapted it for their adult patients with Learning Disabilities.

Next Step

This resource will become part of the introductory pack for patients visiting the practice and it can be easily amended and adapted.

Key Learning Points

The importance of collaboration. There are only about 150 paediatric consultants in the UK. They used to meet twice a year. At the outset of the crisis they met weekly via MS Teams to support each other as guidance and information changed daily. They were able to fast track things that normally would have taken months. There was national collaboration instead of silo working as ideas and resources were shared freely.

Sharing is caring. Be generous with your ideas. Don't do things just for yourself. Don't reinvent something that someone has already done.

Use everyone's ideas. Work with the wider colleague base.

Testimonial

"I love it!"

Operational Manager at CHCP on seeing the COVID-19 Dental Resources for Children Pack

Interviewee: Elizabeth O'Sullivan, Consultant in Paediatric Dentistry.

Video Conferencing and Consultation in Care Homes

Care Home support became a national priority during the COVID-19 response. The ambition of the work was to improve engagement and support with care homes whilst reducing the numbers of people entering and exiting care homes to reduce the risk to residents.

Approach/Methodology

Pre-COVID-19, work was being undertaken to provide improved technology and connectivity within care homes. N3 connectivity was installed, and NHS laptops provided, enabling access to NHS email addresses/accounts.

As the COVID-19 pandemic escalated, an increased requirement for remote methods of consultation between clinicians and care homes became evident. A workaround with AccuRx (GP video consultation) was formulated, utilising an email link accessed from laptops. This proved problematic and far from ideal.

There was a need for rapid deployment of smart devices which were 4G-enabled, ensuring portability around the care home setting. Support/training for Care Home staff was provided for use of various platforms, such as Zoom, Go To, and Microsoft Teams.

There was a need to bring care homes into the NHS "architecture" as some care homes have their own systems and are reluctant to adopt another system.

Impact

Care home staff have reacted positively and efficiently to the introduction of new technology solutions. This has been a "quantum leap". They have fully accepted the need to go virtual to reduce footfall and eliminate cross infection.

Primary Care have extended their use of video consultations, which has enabled care home staff to discuss patients directly and resulted in less inappropriate and costly transportation/visits.

The use of technology has enabled contact for residents and their families at a very worrying and frightening time.

Staff training has continued on a digital platform where face-to-face wouldn't have been appropriate.

COVID-19 has accelerated the deployment of other technology to care homes, such as the Electronic Palliative Care Co-ordination System (end of life pathway) and care homes are now proactive in suggesting new apps and other 'add-ons' such as NEWS2 and MUST tools, alongside apps to monitor a patient's health such as Blood Pressure monitors, pulse oximeters and digital thermometers.

The changes will have a future impact on pathways, and an increase in assisted technology will result in further improvements.

Next Steps

There are some barriers to overcome in relation to some larger care providers with their own IT systems and it will be imperative that the devices are appropriately used going forwards, particularly with regard to imagery and camera usage.

Improved IT platforms will have financial implications going forwards. Further outlay will require a business case, but it is believed that there will be both quantitative and qualitative data to support this. There will also be cost implications for Integrated Personal Commissioning (IPC).

Learnings can be applied to other areas of social care such as domiciliary care.

Key Learning Point

The customer (care home) needs come first. Focus must be around their requirements first, and then the CCG requirements.

Testimonial

"Anecdotally, everybody says some groups of people cannot adopt IT, there is a generation out there who cannot use it/ won't use it, but my experience, probably because of COVID, is you would be surprised how many people can learn to use it quite quickly if you make it straightforward."

Bruce Bradshaw – Strategic Lead North East Lincolnshire CCG

Interviewee: Bruce Bradshaw, North East Lincolnshire CCG.

Jean Bishop Integrated Care Centre: Community Frailty Support Team – Hull and East Riding

In response to the COVID-19 pandemic, it was predicted that high infection levels and mortality rates would overwhelm the healthcare service. A system-wide approach was needed to ensure the right care was offered in the right place, at the right time, for frail residents living in their own homes and care homes.

Approach/Methodology

The Comprehensive Geriatric Assessment Model which was delivered at the Integrated Care Centre (ICC) pre-COVID-19 ceased with immediate effect. The service was redesigned to respond reactively to urgent demand and was replaced by the ICC Community Frailty Support Team (ICC – FST).

The ICC-FST consisted of three key work streams:

- Specialist Frailty Advice and Guidance Line
- Care Homes Outbreak support
- Community Beds Response.

Operational hours were increased to a seven-day service with coverage across both Hull CCG and East Riding CCG footprints. The team worked collaboratively with colleagues in London and key stakeholders to create the delivery model.

They initially considered running the pre-COVID-19 proactive model alongside the new reactive model, but saw this was not achievable as it was deemed too unsafe to bring vulnerable patients into the ICC. The ICC-FST changed the process to allow all health and care staff to have direct access to their service, including those in care homes.

Impact

This model was successful due to the collaborative approach of system partners. Yorkshire Ambulance Service saw paramedics using the advice and guidance line directly. This resulted in a significant reduction in unnecessary conveyance to hospital for patients that could be safely managed in the community.

Initially there were difficulties with distributing medication around the region,

particularly concerning holistic end-of-life care. A team of "runners" consisting of redeployed City Health Care Partnership and CCG staff was developed and Electronic Prescribing was utilised to address this concern.

Communications were also key and were managed through the CCGs and Local Authorities to ensure timely and accurate information sharing.

Next Steps

The team are continuing to collect and analyse robust and timely data to inform operational resilience and planning.

They wish to maintain the reactive service while they start re-establishing the proactive pre-COVID-19 service. A workforce review will be undertaken to sustain this new model of service.

Wider service redesign and alignment to community services and primary care will need leadership and resource to mitigate against the risk of destabilising the excellent outcomes achieved pre-COVID-19 for anticipatory care.

Key Learning Points

Collaborative working with primary and community care was important to utilise their knowledge and understanding of population needs. Collaboration also enabled learning from other specialties and colleagues.

Effective communication structures ensured timely and accurate sharing of information and patient records.

Testimonials

"Our rate of conveying patients to hospital after being attended by a paramedic is currently at its lowest ever point and it looks like this service is likely to be playing a positive part in enabling that in the area."

Deputy Chief Executive, Yorkshire Ambulance Service

"This is the most awesome document I've seen in a long time! It's brilliant and absolutely what is needed."

Consultant Infectious Diseases in reference to the guidance to primary care

Interviewees: Dr Dan Harman and Dr Anna Folwell, ICC Community Frailty Support Team.

Rapid Discharge Process – York/North Yorkshire Control Room

Pre-COVID-19, a significant proportion of the discharge process was spent within acute hospital settings, completing assessments and evaluating the continuing needs of patients. In addition to this, an increased choice of care homes for self-funding patients can result in additional delays and constraints.

National Guidance requested a rapid approach to the discharge of patients from hospital as a result of COVID-19 whilst still maintaining patient assessment and aftercare.

Approach/Methodology

The process developed in York involved a discharge to assess process, where a patient would be discharged from hospital to have a needs assessment either at home or in a community bed/care home. The removal of bureaucracy and funding decisions has positively impacted this process, as teams were able to work together to align the best pathway for the patient and to ensure their needs are met at the correct level.

The pandemic has highlighted the fact that not all decisions are required to be made within a hospital setting. This shift towards home assessment has been identified as the correct course of action to follow to satisfy the best interests of the patient.

Impact

At a time where people have been very frightened, both patients and their relatives have reacted in a positive way to the changes made and have described the process as seamless. Communication has been described as excellent and due to the obvious lack of physical, face-to-face contact, care has been taken to ensure each patient has received regular check-ins to ensure the discharge process has been smooth. Follow-ups with patients who are on end-of-life pathways have been a key priority.

From a staff perspective, the changes have resulted in an obvious shift in workload. The new single document is lengthy, and completion has been a challenge, especially for staff working on the wards. Current ways of working will need to be addressed and reassessed.

Investment has been made into domicile rapid care, where response is given within a two-hour time frame. Due to the benefits found in this, the service has been extended, and a business case to keep this is currently under preparation.

Next Steps

The team are working to embed the discharge to assess model. Work is being undertaken with York Hospice, around support for patients at home on Pathway 4, end-of-life care.

A review of team resourcing is required, due to the substantial amount of work required which cannot be sustained long-term at the current pace.

It is hoped that shared funding will continue, to enable staff to have a greater freedom around improved decision making.

The national policy and local governance require review in order to take learning from this work and work like this from across the country.

Key Learning Points

The removal of bureaucracy has broken down barriers and enabled faster and efficient discharge and decision making for patients and their needs. Providers of Care are key to success, they need to be party to the vision and what we are trying to achieve.

Interviewees: Gillian Younger, York Teaching Hospital with North Yorkshire Control Room.

Delivery of Pulmonary Rehabilitation Services across Humber, Coast and Vale

Chronic Obstructive Pulmonary Disease (COPD) affects approximately 2.2% of the population in Humber, Coast and Vale (HCV) and contributes to approximately 11.3% of unplanned hospital admissions for the region.

Pulmonary Rehabilitation (PR) is viewed as an important part of a COPD patient's recovery and self-management. It generally consists of group sessions involving education about their condition, exacerbations, management etc. alongside an exercise programme tailored to a patient's ability, aimed at increasing fitness and lung function.

When the COVID-19 pandemic came to the UK, all PR classes were suspended. This is due to the following three factors:

1. This cohort of patients were a vulnerable group and more susceptible to a virus which causes respiratory problems.
2. Infection risk and spread of the disease are more likely in face-to-face interactions.
3. Some staff were redeployed to frontline services.

The Yorkshire and Humber Pulmonary Rehabilitation Professional Network who meet regularly to share practice and experience were able to share thoughts and ideas on how to proceed with PR delivery, as there had not been any National Guidance apart from being told to suspend clinical activity.

There was an acknowledgement from across the region that PR needed to continue in one form or another for these patients, to enable them to stay healthy at home and prevent hospital admissions. The Humber, Coast and Vale region has varying levels of rurality and deprivation which means that the delivery of PR had to be tailored to the environment to ensure patient involvement and inclusion.

This report therefore covers three examples of how PR is being delivered across the region:

1. York Teaching and Humber Teaching Trusts delivering individual PR to patients.
2. Care Plus Group in Grimsby delivering PR via Zoom.
3. Pilot in North Lincolnshire CCG looking at virtual reality PR.

1. Pulmonary Rehabilitation (PR) by York Teaching and Humber Teaching Trusts

The York, Scarborough and Ryedale area have high areas of deprivation. As such, ten out of the first 16 patients contacted did not have access to the internet. The team developed a solution which would be equitable for their region.

Approach/Methodology

The staff working in the community (Humber) were provided with the autonomy to redevelop their service as they saw fit. Both Humber and York trusts worked together to discuss the options available to deliver PR without the face-to-face element.

It was agreed that a British Lung Foundation DVD would be utilised alongside education and exercise workbooks for patients. Patients were telephone-triaged at the beginning, using an updated form to assess suitability aspects and technology availability. They also wanted to ensure patients were comfortable with the new format and to individually tailor the workbooks for each patient.

Patients have to opt in to this six-week virtual programme which involves doing exercises at home with a weekly follow-up call to discuss progress.

Impact

This work involves one-to-one support with patients, which is a lot more resource intensive to deliver than previously. More staff are required to deliver this service for all the patients who need it.

Because this is an opt-in programme, the patients doing the PR are engaged and adherence is good. Their feedback on the programme has also been positive. It is hoped that because these patients have had to self-motivate at home to do the exercises, after the programme stops, they will continue the exercises and manage their condition safely at home.

The evidence-base around the remote delivery of PR is lacking and this programme has only been running for a few weeks, so the outcomes are not well known. It is also important to recognise that by delivering this programme virtually, patients miss out on the peer support element which is available in the face-to-face PR programme.

Next Steps

The team are considering using a platform such as Zoom or Attend Anywhere to hold the education sessions. The decision around this is pending. Due to the large number of patients who don't have access to technology, the team don't want to create more inequality by implementing technology.

The team are working with the Local Authority to both upskill carers with technology and improve their confidence using it. They have also submitted a funding bid to be able to distribute devices to patients for use in PR.

The new service hasn't been running very long and will need to be evaluated in the future.

Key Learning Points

The cross organisational working, especially involving the Local Authorities, has enabled better insight into the services and understanding of the population.

This has been an opportunity to really look at the service being delivered, learn from others and look at ways of delivering PR differently to improve access to the programme during and after the COVID-19 period.

This has impacted the workforce with additional workload so this must be considered during set up.

New resources mean governance processes need to be followed, and costs and timelines to get through bureaucracy need to be considered.

Interviewees: Alex Kilbride, Vale of York CCG, Bev Quarton, Humber Teaching Foundation Trust.

2. Care Plus Group Delivery of Pulmonary Rehabilitation (PR) using Zoom

The Care Plus Group focus on co-creation and development with their patients and the public to ensure services are optimised for patient use. The PR programme at the Care Plus Group involves the use of cognitive behavioural therapy and peer mentorship in the education part of the programme. They wanted to be able to continue delivering this method virtually and chose Zoom as the platform for PR.

Approach/Methodology

At the start of the pandemic, all patients were contacted by the team to triage needs. Those who were eligible were provided with the MyCOPD app to support patient self-management.

The team assessed potential platforms for the continuation of PR and agreed upon Zoom as the best platform. When talking to patients about PR, the team found that approximately 10% of patients didn't have access to the internet. Of these, most were receptive to technology if it were provided and the team supported their patients with using Zoom.

One of the key functionalities Zoom offers over other platforms is the ability to have breakout rooms. The patients are able to have the education and peer support aspect of the course together but are then assigned breakout rooms to complete the exercise element and clinical discussion. Physiotherapists and Occupational Therapists were able to attend these breakout rooms if and when needed.

Risk assessments and disclaimers have been amended to reflect the difference in service delivery and the preassessment process has been streamlined. Patient assessments have also been amended to reflect the change to delivery whilst continuing to monitor a patient's progress.

Impact

The first virtual PR course is still taking place so the impact of the course cannot yet be assessed.

The work now involves one-to-one interactions with patients, which means staff workload is impacted and fewer people can be on PR programmes at one time.

The use of Zoom has been so successful that the Care Plus Group are utilising it for other services as well as non-clinical and social items such as quizzes and Q&A sessions with staff.

Even though the first programme hasn't finished, patients are already reporting that their activity has increased, as has their confidence.

Next Steps

The Care Plus Group and North East Lincolnshire CCG are looking at ways to support patients who don't have access to technology. Training will be provided for those patients comfortable with using this technology.

When the first virtual PR programme has been completed, the team will be evaluating the course and its impact both from a staff and patient perspective. This will then inform changes needed before the next course begins.

Expect moving forward some PR will be delivered virtually and some will go back to face-to-face interactions. The team feel there will be some benefit of virtual meetings for those patients who may not be able to attend in person due to illness and would have previously disengaged.

Key Learning Points

The relationship between the Care Plus Group and North East Lincolnshire CCG is strong, meaning the group had the freedom to deliver services as they felt appropriate and were supported by the CCG to do so.

Interviewees: Gaynor Rogers, North East Lincolnshire CCG and Pamela Hancock, Care Plus Group.

3. Virtual Reality Pulmonary Rehabilitation (PR) Pilot in North Lincolnshire

Due to the rurality of the North Lincolnshire area, some people struggle to access hospital and GP appointments and clinics.

In response to this, North Lincolnshire CCG has been working in partnership with Concept Health and Manchester Metropolitan University to pilot a Virtual Reality (VR) PR programme to address this.

Because this programme was not run face-to-face, it was continued throughout the pandemic.

Approach/Methodology

Concept Health provided North Lincolnshire CCG with 'kits', which included VR headsets and wrist devices. Participating GPs identified qualifying COPD patients and provided them with the kits to participate in a six-week PR programme at home.

The programme allows the patient to access modules via the VR headset, including educational modules about how to manage their COPD symptoms, as well as active modules, which get progressively more difficult.

The setting of the VR module is designed to encourage participation and incentivise the patient to complete the programme by including a choice of relaxing settings (e.g. the beach), as well as the ability to view heartrate and oxygenation level statistics on-screen.

A sense of community is conveyed through the use of virtual workout partners – two other virtual participants can be seen taking part alongside the patient during the programme. This allows the correct technique to be demonstrated, whilst also ensuring that the patient does not miss out on a sense of community and membership that they would have otherwise experienced as part of the traditional in-person clinic.

All of the statistics from the wrist device are able to be monitored remotely, allowing clinical intervention where issues arise. Furthermore, if patients do not take part in the programme for three consecutive days, they are contacted by the Concept Health Team to understand the reasons behind this and provide support to enable compliance with the programme.

Impact

All patients are able to access the same support regardless of where they live in the region.

This PR service has been able to continue throughout the COVID-19 period, as the programme is able to take place at home.

Patients are empowered to decide where and when they complete the exercises, meaning there has been a high compliance rate (95%).

Next Steps

As the pilot is in its early stages, further analysis of the ongoing feedback will be taking place at Manchester Met University.

Work is ongoing to raise awareness of the programme through local working groups to encourage more GP surgeries to take part in the pilot. Furthermore, there is an appetite to link this work with secondary care.

Key Learning Point

Throughout the process it was important to ensure that the pilot was owned and signed off by CCG Executives, and the pilot needed to be accompanied with a structured promotional campaign. A clear comms strategy surrounding the pilot will mean higher levels of participation from GPs.

Testimonial

One patient stated that she found the programme easy to use and quite straightforward. She would definitely recommend it to others. The staff were very supportive and helpful and she would like to be contacted directly to return to the programme instead of having to go through the GP, as she can now walk to the end of the garden and back. If the product was available to buy on the market, she would consider it as it has been so beneficial to her. She liked the technology and the fact that she could do the exercise in the comfort of her own home and in her own time. She is very satisfied with the programme and all of its elements.

Interviewee: Chloe Nicholson, North Lincolnshire CCG.

The 'Ask a Midwife' Service

The Local Maternity System (LMS) in Humber, Coast and Vale have not had the option to pause or reassign their workload during the pandemic – whilst concern about COVID-19 was at its height, the babies kept coming!

It was therefore really important that the LMS found a way of communicating with women and families to:

1. keep up with the rapidly changing situation
2. reassure them about concerns
3. highlight any messages around how maternity services were being delivered which they might need to know during their pregnancy or labour.

The 'Ask a Midwife' Service, hosted on Facebook was set up to support parents with a consistent message across HCV. It has reallocated and optimised available resources to continue supporting women and families during the pandemic.

Approach/Methodology

The approach was developed by the team at Hull University Teaching Hospitals NHS Trust (HUTH) because they already had a Facebook page running. The process created in HUTH was then utilised by North Lincolnshire and Goole NHS Foundation Trust (NLaG) and York Teaching Hospitals NHS Foundation Trust, with the content adapted to reflect local needs.

The 'Ask a Midwife' Service was coordinated by the LMS to ensure a consistency of delivery and messages around the system. The LMS developed 'Frequently Asked Questions' and other resources which the three sites were able to utilise. This supported the consistent approach and aligned voice across Humber, Coast and Vale.

The Hospital Trusts were able to quickly provide equipment to the Senior Midwives who were shielding at home, which enabled the service to start rapidly across all three sites. The midwives provided accurate, appropriate and timely information as well as answers to queries in order to continue supporting their patients.

Impact

An audit in one area of the service highlighted that 91% of messages were answered by the service; of the remaining 9%, 3% were referred to the Antenatal day unit, 3% to community midwifery services and 3% to labour ward.

Up to the end of June 2020, HUTH had answered 3,750 personal messages to their page. These have been categorised for future development and will enable the service to be reactive to policy changes, patient queries and to post timely information.

In NLaG the number of views on the Trust Facebook page has increased by 1,800%. Posts had reached 70,000 people by the end of April and the first post alone had 13,300 views.

At York Hospital, the post covering changes in visiting received over 21,000 views; this supports the LMS findings around new information being disseminated in a very timely manner.

The service was well received by parents and as the service developed, the teams saw a change in the types of questions being asked. Some parents were building rapport with the midwives on the service and were asking multiple questions because they felt comfortable to do so. They were able to ask questions to the service when they thought of them without feeling like they were 'bothering' a midwife.

In a survey delivered by the local Maternity Voices Partnerships, 98% of respondents in both the antenatal and postnatal surveys said they would use the 'Ask a Midwife' service again.

The midwives delivering the service from home gained a real value in supporting the service and allowing colleagues in clinical areas to have more time to care for their women and families.

Next Steps

Because 21% of all responses were around clinical symptoms, the LMS feel there is value in continuing to deliver this service on behalf of Humber, Coast and Vale. A proposal has been written along with a cost model for continued delivery.

The LMS are also working with Gynaecology Departments to develop FAQs around early pregnancy to provide information and reassurance to women at this stage.

Key Learning Points

Using the local Maternity Voices Partnerships was very valuable as they supported the development of FAQs and ensured the implementation of the service was something parents would find useful.

Testimonials

"That's great. Thank you very much, you've been a great help. This is a great idea too!" Anonymous Parent

"Thank you so much, you've been helpful on every question I've asked." Anonymous Parent

"Thank you so much, nice to hear from a professional, thank you." Anonymous Parent

"Thank you for getting back to me so quick! That's great to know, thank you again." Anonymous Parent

Interviewee: Sallie Ward, LMS Lead Midwife.

Virtual Parent Classes

Due to COVID-19 all classes for expectant parents were cancelled to reduce face-to-face interactions and transmission risks.

There was still a strong desire from the parents to have these classes to prepare for parenthood, as well as maternity teams to share key messages with families.

Approach/Methodology

Each individual trust utilised the technology platform which worked best for them. York Teaching Hospitals NHS Foundation Trust already had online resources available to parents and Hull University Teaching Hospitals NHS Trust (HUTH) Maternity Education Lead amended some of their resources to make them more appropriate for the virtual format. The Local Maternity System (LMS) worked across all three sites to share resources and ensure that the content and delivery of the classes were as consistent as possible, allowing for local information when required.

Face-to-face sessions were generally held with 10 couples, however by moving to virtual sessions, it was felt that this number was a challenge for staff to manage and facilitate effectively. This resulted in the virtual groups being reduced to six couples.

One-to-one classes were also trialled at the beginning, but it was too labour intensive for staff and the families felt they were missing out on the social element that these classes usually bring. A WhatsApp group was offered to each group with the support from the course educators where possible.

This enabled the group to discuss day to day queries as well as socialise outside of the class if they wanted to. This commenced at HUTH initially and spread across the LMS.

The LMS were able to share useful links such as support sites and the LMS website with parents via the WhatsApp groups.

There were some challenges encountered; from moving people from the current booking system, to consenting them, or moving to a different system to facilitate the virtual meetings. Admin resource was needed to do this.

In addition to these classes Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) initiated a Virtual Antenatal Preparation Programme in North Lincolnshire in collaboration with the North Lincs Children's Centre and Baby Feeding team to support parent preparedness and increase their knowledge.

A Virtual Group Agreement was developed for parents before the course in order to make staff and parents feel comfortable with the format of the programme and expectations around behaviour and confidentiality. The group utilised Microsoft Teams software to hold four one hour groups discussing the developing baby brain and attachment, managing stress and anxiety, how parents want to behave as parents, communication and managing parental conflict in a healthy way, feeding, and practical baby care.

Pre- and post-evaluations were completed by parents to evaluate the impact of the course. To mitigate limited involvement from local maternity services at the development stage, accredited information was given to parents about labour and pain relief and offered a referral to local midwife for further information.

Impact

Some of the staff who were running these classes were shielding and so felt they were contributing and supporting their colleagues and the parents. In one case, by delivering these classes virtually, the midwife noted they had gained confidence in using new technology.

Reducing the size of the class has meant that more classes needed to be run. Though running more classes takes up staff capacity, by running these virtually, staff time has been balanced from other time constraints such as travel time.

Parents have been receptive to these virtual classes as they have given them important information which in turn has relieved some of the stress involved in being pregnant, especially during a pandemic. These virtual courses have made attendance easier for some families who may have struggled to attend face-to-face groups due to jobs, other children, travel and other factors. Post-course evaluations have showed that the parents have learnt a lot about their baby in terms of development and feeding, how they can communicate and manage conflict and think about how they want to behave as parents.

Next Steps

York Teaching Hospitals NHS Foundation Trust already had an online training facility before COVID-19 with videos online for expectant parents to watch. To facilitate parent preference and enable easier attendance for some parents, running virtual classes as well as the face-to-face classes are being considered moving forward.

Because these classes have been successful, the LMS are looking at how they can deliver the Maternity Carousel virtually, which provides parents with information about some of the practicalities of remaining healthy and bringing up children safely, from lots of organisations and support services.

Key Learning Points

It is important to involve Information Technology (IT) and communications support staff to ensure both staff and parents understand how to get the best out of the technology now being used for many of these interactions. Interoperability of IT from different sites are a challenge and can affect the efficiency of collaboration and delivery of these new pathways.

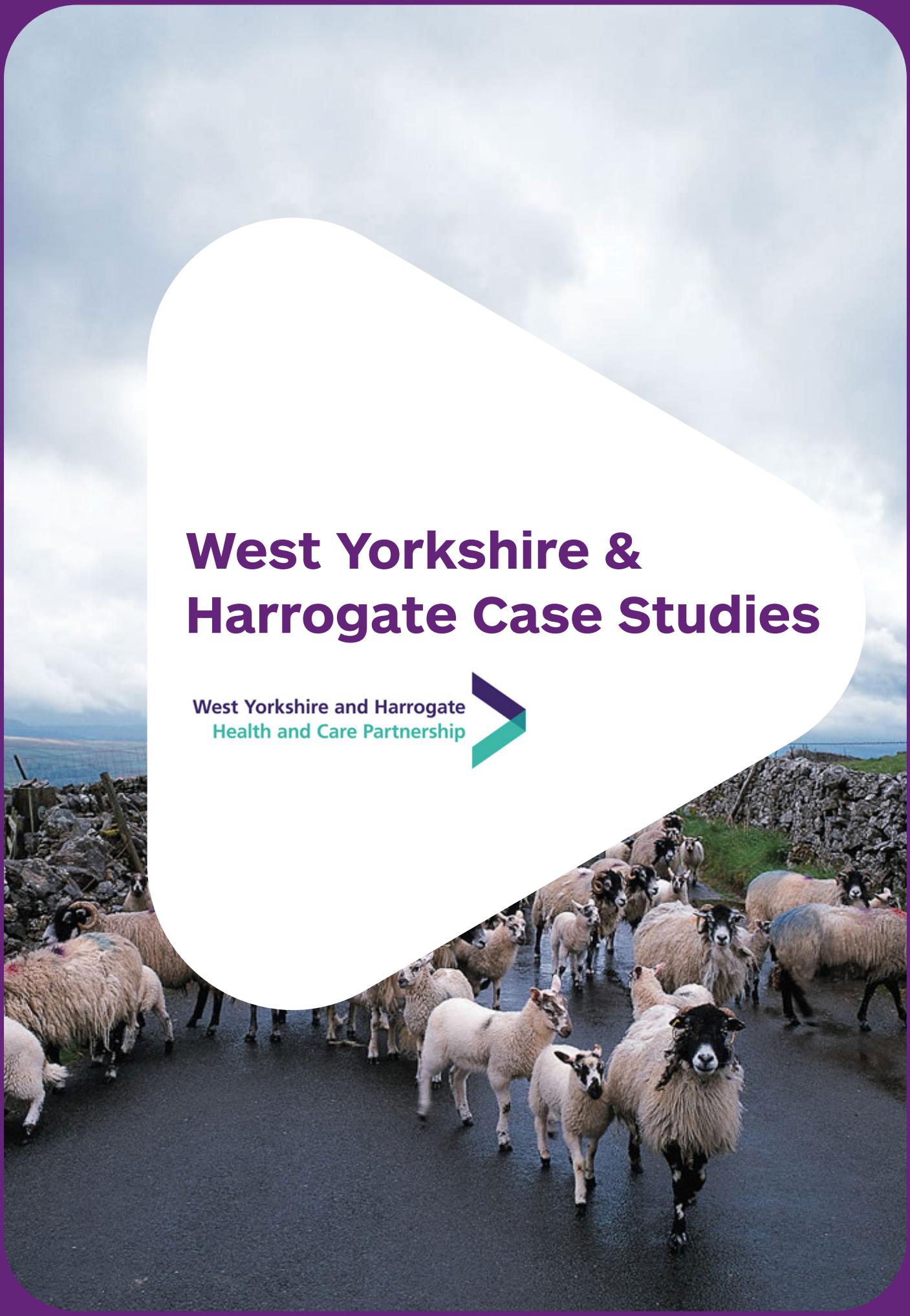
There was national money available during COVID-19 specifically aimed at enabling staff to get the technology they needed to deliver services – such as laptops and software. Moving forward this will not be available nationally and places may have to look at how this can be delivered with existing technology.

Collaborative working was a key enabler to ensuring the delivery of classes.

Interviewee: Sallie Ward, LMS Lead Midwife and Paula Cafferty, Community Practice Educator at RDaSH.

West Yorkshire & Harrogate Case Studies

West Yorkshire and Harrogate
Health and Care Partnership



Electronic Prescribing for Out of Hours Service

Local Care Direct (LCD), who provide the Out of Hours service for West Yorkshire, have wanted electronic prescribing, but it had only been made available to in-hours GP surgeries. LCD works across six Clinical Commissioning Group (CCG) areas so commissioning this resource is complex.

Most LCD GPs wanted this facility and were already used to using it in their daytime surgery. TPP, the developer of SystmOne, had a solution ready. The change hadn't been given the go ahead before COVID-19.

Approach/Methodology

The barriers preventing the implementation of electronic prescription for out-of-hours services were flattened by the COVID-19 crisis. Consequently, it was introduced at the end of March with relatively little hassle and over 90% of prescriptions are now issued electronically.

Impact

The implementation has been 99% successful. It has resulted in almost no faxes being sent (admin staff in the LCD call centre used to send one fax every 15 minutes or so, now it is rare to see one per day).

It has changed processes. Something that was predicted to take many months to implement was done in a week or two.

LCD clinicians are now able to work via the LCD Virtual Private Network and get prescriptions delivered accurately, quickly and safely, direct to pharmacists wherever they are, which makes processes of care more efficient, and safer and faster for patients. It's easier for clinicians to complete. It's a win for patients, clinicians and patient service and patient safety.

It has been seen as a successful innovation and the culture of LCD is now shifting towards embracing technology, for example, the use of Microsoft Teams instead of face-to-face meetings and conference calls.

Next Steps

To be able to adopt more digital innovations that would result in improved workflows, time and cost efficiency, such as expanded use of Microsoft Teams, video and online consultation.

Key Learning Points

Coronavirus enabled rapid change in processes and broke down the previous barriers that had prevented change.

Digital innovation has been seen to support system change, resulting in greater efficiency in working practices.

Testimonial

"Every time you hear someone telling you it's too complex, too difficult, remember that in Covid time, you just did it."

"Crises create leverage…it's a time of crisis, but also opportunity."

Interviewee: Dr Peter Davies, Clinical Advisor, Local Care Direct.

Allied Health Professionals at Airedale Hospital

Due to acceleration of the COVID-19 Pandemic, and following on from Government advice, it became necessary to suspend some usual activity and concentrate on urgent/priority work within both community and acute settings.

Approach/Methodology

Staff from within the therapy teams were quickly redeployed into areas requiring additional support. This resulted in several services being temporarily suspended to give priority to urgent work, for example new referrals and triage. Non-urgent outpatient activity was halted, resulting in many services being given a virtual option via Attend Anywhere.

Staff were pulled from the large musculoskeletal service team, into an acute patient team, allowing a seven-day footprint, while also enabling extended working days (8am-8pm). This change enabled an increase of therapy on the wards, resulting in speedier discharge.

Prior to COVID-19, there had been a lack of multi-disciplinary input within critical care areas, but the rapid changes put in place supported the doctor/nurse workforce, thus enabling safer staffing, and implementation of therapies which traditionally had little input (dietetics/speech and language etc.).

Support was also given on acute wards for proning of patients. Three to four therapists supported a proning team, providing 24-hour support to doctors and nurses who would otherwise have not had capacity.

Impact

The workforce was dramatically affected in the early weeks, sometimes reduced by approximately 25% due to shielding, testing and self-isolation.

Work teams were split into ‘Hot’ and ‘Cold’. Many of the cold team caught COVID-19 because initial advice was to use PPE in hot areas, resulting in major learnings.

Increased resources within teams (i.e. discharge teams, nursing teams) improved the diversity of the workforce and feedback indicates this skill set has made a huge impact, providing additional capacity and improvements to the discharge process.

Changes have enabled more involvement in a multi-disciplinary capacity, for example social care, and a virtual MDT for people with complex needs. Teams from different organisations have been able to pull together to solve issues and meet patient needs in a coordinated way.

Next Steps

The seven-day service during COVID-19 has worked well by providing support to enable patients to be discharged quickly and enabling the follow-up of a cohort of patients with post-COVID needs. There is keen interest to maintain this but will require planning and investment to make this a normality.

Some key learnings were made around PPE which will require follow up.

Significant changes and improvements have been made within the acute team and one of the challenges will be how to move this forward.

Resource requirement has been highlighted within the Emergency Department, where minor injuries were separated out. An example of this is a seven-day physiotherapy service, providing a 'one stop shop' for treatment and follow-up care, reducing footfall in hospitals. Providing shared skills enables a thought process around what the workforce requires moving forwards and potential remodelling of services.

Key Learning Points

Having a motivated workforce with a 'can do' attitude is essential to cope at unprecedented times. They have enjoyed the challenges they have faced and the ability to support in other areas.

Clinicians have welcomed therapist support on wards and want to keep this service.

Staff levels require a reassessment and a baseline requirement.

Interviewee: Freya Sledding, Interim Chief AHP, Airedale Hospital Trust.

Discharge to Assess: Kirklees Council

There was a need to find a way to facilitate discharge from hospital to home that was both safe and timely. The previous decision-making process was slow and drawn out but COVID-19 necessitated quick responses to clients' needs.

Approach/Methodology

There was an immediate core change in practice. The Principal Social Worker and the Principal Occupational Therapist (OT) developed a new Discharge to Assess (DtA) referral form in five hours. The responses were intuitive, highlighting essential information required for transfer, looking at what was needed from a health and social care perspective in terms of a care plan.

Daily DtA meetings were implemented with the local health providers. This meant that rapid decisions could be made involving secondary care, social care, the accessible homes team and occupational therapists.

The new system was operational in the first week of the crisis.

Impact

Feedback received is that the form is so much simpler than the previous assessment form and the social care teams want to adopt this in the longer term. The usual form took 30-40 minutes to complete whereas the new one takes eight minutes, thereby freeing up capacity.

Partners in other local authorities adopted the form, which is in a shared word document that is populated with the required information and used as a rolling document, open to update as more information is obtained. It has resulted in inter-organisational collaboration, especially with the Voluntary and Community sector, which has been a huge learning experience.

Next Steps

There is a common desire to maintain this procedure. There is a plan to assess the changes against the RSA's "understanding crisis response measures" framework.

Key Learning Points

Eighteen months had been spent analysing the DtA process where there was no consensus. The pandemic forced their hand as they realised the need to act fast.

The need to meet the requirements of COVID-19 enabled autonomy to change pathways and streamline assessment procedures.

The system will need to be flexible to respond to ongoing changes as the pandemic situation evolves. For example, families have been able to support relatives as they were confined to their homes. As people return to work there will be a growing demand on services. There will be an increasing focus on the use of assistive technology/devices to maintain people at home.

Testimonials

"The collaborative practice has resulted in a staggering learning experience about how people can pull together in the community."

"Don't be afraid to stand up for what you believe in or challenge if you feel something won't work in the best needs of the clients."

"Look at the value of working together for the benefit of the good, the synergy of the whole system approach rather than little pockets working differently and going down their own route."

Interviewee: Anita Mottram, Principal Occupational Therapist, Adult Services, Kirklees Council.

West Yorkshire & Harrogate Health and Wellbeing

As soon as COVID-19 was recognised as a pandemic, West Yorkshire & Harrogate Health and Care Partnership (WY&H HCP) recognised the effect this would have on the healthcare sector and the need for a pre-emptive piece of work optimising the health and wellbeing of employees to ensure resilience during the pandemic. A health and wellbeing offer for the HCP was developed.

Approach/Methodology

Action was taken immediately, supported by the Chief Officer of Bradford District and Craven CCG. A core group was quickly co-ordinated to support staff wellbeing and this work was then shared across the Partnership, enabled by WY&H's System and Leadership Development Programme.

As the project had already started in Bradford and Craven, this was used as a blueprint to build upon in order to scale up across the WY&H footprint.

From week one of lockdown, a weekly meeting of the Bradford District and Craven core group – known as the Workforce Health and Wellbeing Knowledge & Intelligence Sharing Team (KIT) was convened. There was an open-door policy so anyone with an interest in the health and wellbeing of the workforce could contribute, regardless of their job. The group also included experts such as psychologists and therapists.

The focus was on all sectors: Voluntary, Local Authority and NHS. All suggestions were considered, ranging from prevention and self-management to therapeutic interventions.

A subgroup sifted through the resources to select the most appropriate interventions, which encompassed local, regional, and national ones. They were reviewed for evidence-based practice and a repository was developed.

Draft terms of reference were drawn up in week six to provide an audit trail. The enablement of a webpage was supported to provide front door access across the six Places. The website was launched on 28 May.

Impact

The footfall on the Partnership website will be measured for usage which will be done by Place.

COVID-19 has created an openness to talk about mental health and brought key values, such as genuine caring, to the core.

There has been a refocus on the emotional and psychological health of staff which is now a priority of the partnership and will be key to the retention of staff.

This model can be used in another context.

Next Steps

Phase one is complete, with resources having been brought together to support the health and wellbeing of the workforce. Bradford District and Craven KIT is continuing to work together on its phase two, with outcomes to be shared across WY&H. Longer term, there is a desire to sustain the support beyond COVID-19, with a focus on all areas of life, care and work.

This positive innovation needs to be sustained and spread further to reach everyone in all sectors, including care homes, carers, volunteers.

There is a need to keep the energy and momentum generated from the initial response to the pandemic, to sustain positive learning.

Key Learning Points

"Design once and spread" – the toolkit worked with Bradford and Craven, so adapt, spread and adopt across the whole region.

A common purpose and camaraderie – *"it just happened"* because people got involved who wanted to with no barriers of bureaucracy and governance. New relationships were formed as a result.

The 'open door' approach enables people to engage in meetings according to relevance of the latest piece of work, without becoming a 'permanent' core member of the group. This has led to different people joining in different weeks to contribute their knowledge, intelligence and expertise.

Interviewees: Dawn Clissett, WYH OD Network, Jo Farn, WY&H HCP, Maureen Goddard, Workforce/HR Specialist.

PPE Training in Care Homes

Due to the acceleration of the COVID-19 pandemic, it became apparent that rapid delivery of training was necessary across the care home sector, regarding the use of PPE. Leeds Teaching Hospitals were tasked with this delivery across care homes within the Leeds area.

Approach/Methodology

Leeds Teaching Hospitals requested volunteers to deliver PPE training sessions across the locality with each volunteer being allocated ten care homes. The deadline for delivery of all sessions was just two weeks.

Sessions were coordinated by the Community Infection Prevention Control team. This bridged the gap between community and hospital staff, which, prior to the pandemic, had never experienced this level of integration and collaboration.

Reluctance from care homes posed the biggest challenge for delivery of face-to-face training, due to fears relating to the spread of COVID-19. One trainer, from a BAME background, recognised she was disproportionately at risk, and shared her concerns with the care home staff. She advised that she would ensure all necessary precautions would be taken to reduce infection risk and ensure safe delivery of the training. Face-to-face rather than virtual training was the preferred method of delivery to achieve improved results.

Trainers felt they would not have been able to deliver this level of training in such a short timeframe had they not been released from current roles, due to the time required for preparation and delivery.

Impact

Care home staff reacted positively to the training received and agreed that face-to-face delivery was the correct method to ensure success.

Next Steps

Some evidence of poor practice regarding the use of PPE was identified in some care homes, which has highlighted the need for increased requirement of inspections by infection prevention teams. This will ensure compliance is within the recommended guidelines.

Key Learning Points

Care home staff expressed that they would have much preferred training to be delivered at the start of the pandemic but instead had to wait until much later on.

When delivering training within the care homes, it is important to ensure sessions are delivered in areas where residents do not enter, to minimise the risk of infection.

Training sessions can often result in increased admin work. To avoid care homes having increased admin, prepare required resources and ensure any requirements are emailed ahead of training.

Interviewee: Ashhita Xavier, Leeds Teaching Hospitals.

Using Technology to Continue Supporting Patients

National Guidance required community services to deliver digital-first services. Locala utilised available technology to enable continued delivery of service and support to patients.

Approach/Methodology

Locala were able to build on systems and technology already available within their organisation to enable video consultations and phone consultations. Training was provided by the Transformation Team to frontline staff which enabled them to use the technology to its best advantage. Team members embraced the new technology once they were shown how it worked and that it helped patients.

The adoption of the technology available was discussed with each individual service to optimise service delivery and patient satisfaction. Patient pathways were re-designed using phone and digital approaches, with face-to-face services provided based on patient risk and need, in line with national guidance.

In May 2020, the Transformation Team hosted a series of workshops, each containing a mix of staff from the various services provided by Locala. These sessions allowed staff to share positive impacts and patient stories as well as share concerns and issues and work together to resolve them.

Impact

Patients continued to be cared for through less traditional, more digital platforms which were generally well received.

"Initially, my appointment was cancelled because of COVID-19. I was very surprised to get a phone call instead, so we could discuss what we felt was wrong with my foot. I am now testing out some insoles for my condition. A phone call was much better than waiting for hospitals to be up and running again."

Anonymous Patient on Podiatry Services

Next Steps

The Transformation Team are working with each service to develop reformation plans. These include how to embed the technology and service changes going forward as well ensuring 'digital inclusion' e.g. not all patients are comfortable or able to use the technology.

Locala also want to start piloting and scoping for remote monitoring for some patients.

SystmOne have recently introduced a feature for patients to input readings and for these to be flagged up to staff if needed.

Key Learning Point

Staff training and peer support were important to improve staff confidence in delivery of services.

Testimonial

"Thank you for your video calls whilst we've been in lockdown. It was great that I could see what [my husband] was doing wrong, when you told me and gave me instructions. I've been able to continue helping him with the exercises at home and he has made great improvements. As a result of video calls and the instructions, he is now doing 14 reps of all the exercises and he has lost about three stone in weight. The exercises have given hm great motivation and it's been with your help that this has been achieved. Without the video calls, he would probably have stopped doing the exercises or would have done them quickly and not properly, which wouldn't have achieved anything."

Anonymous Carer on Adult Therapy

Interviewee: Petra Bryan, Assistant Director of Transformation, Locala Community Partnerships CiC.

Digital Change in the Voluntary and Community Sector: Harnessing the Power of Communities

The Ageing Well programme team at West Yorkshire & Harrogate Health and Care Partnership saw there was a need to support the frail and elderly without digital skills/access to digital to communicate with families and friends during the coronavirus.

Approach/Methodology

Kirklees were already testing a digital approach. Systems were in place and when an opportunity arose to trial "portals" it was seized as a comparative study. Facebook, who produced them, were approached to donate some for a pilot in Kirklees care homes and supported housing. One hundred devices were provided within three days. This was a simple solution to keep people connected though face-to-face calls, who have no access to digital technology and also those with learning disabilities. A portal is shared by residents and sessions are booked to use the portal.

Impact

People have really taken to using it, so much so that slots get quickly booked up each day.

Relationships and connections have really improved. Something that would have taken six months to set up was done in two weeks.

Next Steps

The Digital Programme Survey that was undertaken to identify the needs of the Voluntary and Community Sector (VCS) showed a huge number of needs from small church and faith groups to larger organisations.

An investment in digital hubs in communities is being looked at. They could also have the potential to deliver healthcare services.

Infrastructure leads who connect with smaller community groups and Health Watch are to be invited to sit on the West Yorkshire Health board to find a model that will support people to access technology and digital innovations.

A business case is being submitted for the NHS, CCGs and LAs to each commit to a budget specifically for the VCS for a minimum of five years.

Key Learning Points

The importance of making links. Partnership working in trying to find solutions. A common purpose made things happen quickly.

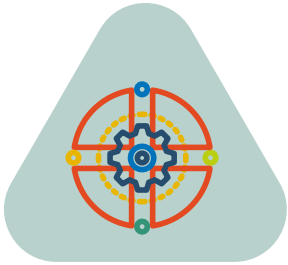
Online community events have gone a long way towards filing the gap of social interaction and can have a huge positive impact but there must be a more inclusive approach to the use of technology particularly amongst older people and those from black and ethnic minority groups.

Testimonial

"I'm a real believer in working alongside people...you listen to what they need, you talk about solutions and then you try and make that solution happen."

Interviewee: Jo Baker, Programme Lead: Harnessing the Power of Communities.

Patient Transport Service (PTS)



Prior to the COVID-19 pandemic, there were a number of variations to booking a Patient Transport Service journey across Yorkshire and North Lincolnshire.

In some areas, patients were able to book their own transport. In others, Healthcare Representatives (HCRs) predominantly booked transport for patients

Across some hospital sites, bookings were made through a Patient Administration System (PAS).

With ambulance services experiencing an overwhelming number of transport requests, all existing PTS contracts and national eligibility criteria were suspended during the pandemic. Online booking was postponed and all journeys were to be booked by a HCR, to focus on discharging patients or providing transport for essential appointments.

Following the reinstatement of health and care services, patients in all parts of Yorkshire and the Humber, as well as North Lincolnshire, are being encouraged to self-book their transport using the Single Point of Access (SPA) telephone line.

Approach/Methodology

From Monday 22 June 2020, all patients requiring transport with PTS were encouraged to phone the SPA on 0300 330 2000. All patients are screened to confirm that they have a medical or mobility need for transport. HCRs are still able to make bookings, but self-booking is encouraged where possible.

Due to this approach, early analysis of aborted journeys show positive trends. Further analysis is required to confirm the reasons for this change, however, the booking information received from patients appears to be of greater quality and it is thought that patients are more likely to provide updates on their need for transport, or their transport arrangements when arranging it themselves.

Impact

Patients have been empowered to self-book transport which has provided them with the opportunity to make choices about their care.

Booking details are more accurate and appropriately triaged in line with national guidance, and HCRs are able to spend less time booking transport on behalf of patients.

Some challenges were encountered by acute providers who had to adjust their processes with little notice, but work has taken place to collaboratively produce patient and staff information materials.

Positive feedback from patients shows they have responded well and complemented the service, given they have direct influence over their transport as an element of their care.

As part of Yorkshire Ambulance Service (YAS) evaluation from PTS business intelligence analysis, data shows increasing numbers of patients self-booking transport in West and South Yorkshire areas – 3.9% of journeys booked by patients had to be aborted, compared with 7.6% of journeys booked by HCRs.

Next Steps

Patient self-booking has proved beneficial and, going forward, YAS will be looking at an analysis of cost savings, operational efficiencies and charting the numbers of patients booking their own journeys. Further development of communication will be required to ensure system partners, outpatient departments and acute trusts support and encourage patients to adopt this practice where appropriate.

Key Learning Points

YAS have grasped opportunities for innovation and change as they occurred and continue to evaluate progress to ensure it is the right change. The sudden need to provide single-occupancy journeys and act as a regional co-ordinator for all PTS providers in response to the COVID-19 emergency placed significant pressure on the Trust. The aim is that patient self-booking will improve operational efficiencies and improve the patient experience.

Testimonial

"I think that patients self-booking in West and South Yorkshire has absolutely had an all-round positive impact.

"Self-booking for patients means that they are able to make choices about their own care, i.e. what would be best for them, their needs and preferences. I believe this makes our service more personalised – patients are able to put a voice to the YAS name and directly tell us what would be best for them. Feedback that we have received has also shown that the majority of our patients prefer to manage their own transport bookings."

Senior Call Handler, PTS Reservations for YAS

Interviewee: Jordan Wall, System Support & Delivery Manager at Yorkshire Ambulance Service NHS Trust.

Remote BAME Patient Engagement

West Yorkshire & Harrogate Cancer Alliance were keen to continue engagement with patients and the public, especially those in Black and Minority Ethnic Groups (BAME) during COVID-19, and were able to do this virtually by utilising Zoom.

Approach/Methodology

A meeting with the Cancer Alliance's patient panel was planned for April with the Living With and Beyond Cancer programme to discuss why the BAME community may not access services.

The programme team decided that it was valuable to keep this meeting in the diary but changed the format from face-to-face to a virtual meeting using Zoom.

A trial meeting was established before the workshop to train the panellists with using Zoom and to build their confidence with using the technology.

The Cancer Alliance staff also engaged with patients to inform the tumour-specific Optimal Pathways Groups (OPGs) on changes made during COVID-19 to cancer service delivery. The OPGs were suspended during COVID-19 due to staff being redeployed and this work will support the OPGs when it starts up again.

Impact

After the training, the panellists felt comfortable to use Zoom for the focus groups and felt like they were doing something productive during a difficult time. They also found it was good for their wellbeing as they developed confidence in using the technology and used it to keep in touch with others, such as family members, which they may not have done without the training.

More work was needed upfront to explain to the panellists why the Cancer Alliance were needing patient and public engagement, and how their feedback will feed into the work being managed by the Cancer Alliance and the wider picture. It had to be clearly articulated to the patient panel members that their feedback would be used to inform clinicians before any changes to pathways are made and that providing feedback doesn't mean that the participants will be moved onto a different clinical pathway to the one they were currently on. However, the patient insight will shape the service delivery for a whole population of patients.

Next Steps

The Cancer Alliance are looking into whether they need to maintain patient engagement virtually. Though face-to-face engagement is the preferred model of delivery, the safety of panellists and staff need to be considered.

Key Learning Points

It is more challenging to pick up on the subtle body language cues you would get from facilitating a face-to-face focus group, especially while discussing challenging subject matters.

It is important to get to know the panellists and have empathy when talking to the patient groups. Don't do everything by email, keep engaged by having virtual conversations and should training need to be delivered, then this will have to be managed to support the participants needs.

Testimonial

"In a normal meeting sense, you can talk with people for 10/15 minutes afterwards, but in this situation [video calling] it feels like you press the button, and everybody's gone."

"It definitely brought out a human element in people, where we were all reaching out to each other and trying to keep contact in any shape or form."

Interviewee: Safya Khan, WYH Cancer Alliance.

Delivery of Outpatients: Calderdale and Huddersfield FT

Calderdale and Huddersfield NHS Foundation Trust's (CHFT) Outpatient Transformation Programme had plans to expand the number of virtual consultations undertaken in Outpatient appointments. The COVID-19 pandemic accelerated these plans and the training programme for clinicians was redesigned.

Approach/Methodology

The team worked closely with Microsoft to trial their applications such as the Booking App. This relationship enabled the process to be refined and amended as they went along.

When the guidance from NHS England was released regarding cancelling outpatient appointments for all but essential care, the Trust were in a position to be able to convert a number of essential appointments into telephone or video consultations.

This was particularly important for cancer appointments where patients were immunosuppressed, and where infection risks were high in the hospital setting. The use of video/telephone triage for cancer pathways was also valuable for first appointments in specialities such as respiratory as it enabled the streamlining of patients and a straight-to-test approach.

The Trust quickly developed online training and webinars for clinical staff on delivery of video consultations. This training reached specialties wider than the traditional outpatient services and included some care homes and many community-based services.

Impact

The implementation of these technologies was rapid and what was planned a one-to-two year project was condensed to a few weeks. This led to a challenge in changing culture and behaviour, especially for the use of video consultation, as some staff were anxious around their skills to use the technology and felt more comfortable using telephone consultation.

There were also a significant number of colleagues working from home during this period, which presented a challenge for the trust to ensure teams had the appropriate equipment and environment to work in, and that the Trust's IT infrastructure was able to facilitate such a move in demand.

Feedback from clinicians highlighted the benefit of not travelling between clinics and the more efficient use of clinical time through remote and virtual working.

Patient feedback is vital to the ongoing development of virtual care. All patients who had a video consultation were sent a survey to understand their experience. Overall, the feedback has been positive, that it is simple to use and that patients would use it again. The survey also highlighted that people's perceptions and acceptance of digital technologies has moved during COVID-19.

Next Steps

Large engagement with the public around their attitudes to health during COVID-19.

To utilise remote prescribing during remote consultations and send prescriptions directly to community pharmacies.

Evaluating how the future of outpatients will run and what proportion of consultations will be remote and face-to-face.

The Trust is undertaking a wide engagement process to understand what has worked well during this period that needs to be embedded into future models, and what could be improved upon to develop new ways of working across the system, building upon the partnerships and pathways that have strengthened over recent months.

Key Learning Points

Engaging with clinical teams across the system and learning from each other.

Identify people who will champion the technology, listen to people, and help address any concerns that colleagues may have.

When collecting patient contact data, an email address should be a default, just like a telephone number, to enable virtual consultations to take place. We need to think differently from first contact with patients.

Work closely with all teams across the pathway – it's often a complex journey that spans primary, secondary and community care.

Ask people to try virtual – they may be surprised!

Testimonial

"We are now looking at the governance framework to take this learning forward and how we provide some strong leadership in a similar way to what we've done in the past with our Outpatient Transformation Programme, ensuring we embed the learning and we don't just go back to 'business as usual' – it's 'business better than usual'."

Interviewee: Lisa Williams, Assistant Director of Transformation, Calderdale and Huddersfield Hospital.

Outpatients Discharge: Leeds Teaching Hospitals

As Coronavirus cases accelerated, instruction was given from NHS England and NHS Improvement to discharge all medically fit patients from hospital settings, to enable acute hospitals to be ready and fully prepared for the anticipated influx of COVID-19 patients.

Approach/Methodology

The initial numbers quoted were extremely high and therefore the requirement was to empty as many beds as possible.

To enable this to happen effectively, Leeds Teaching Hospital worked with other parts of the system, including community providers and Local Authority, with a policy of discharge to assess.

The first tranche of patients were discharged to their own homes, as this is recognised as the best setting. However, for some patients an alternative pathway was required, and consequently additional beds in care homes were commissioned.

On 19 March 2020, a lengthy document appertaining to patient discharge was released, detailing 'must do's' to be implemented for each organisation. A key objective of this was for patients to move within an hour of a decision to discharge, to a discharge lounge prior to going home/into a care home.

On 2 April 2020, further guidance was issued relating to issues around the care home community and care homes needed to be comfortable about taking patients back into care. This was mitigated with a new requirement to test all patients 48 hours prior to discharge, and development of a step-down service for patients until care homes were happy to take them.

Patients have understood and positively accepted/engaged with the changes surrounding discharge.

Impact

Some issues were identified around testing capacity; however, this was seen to be a priority by the pathology department, who gave the go-ahead to test everyone prior to discharge.

The loss of specialist beds due to conversion to COVID-19 beds have resulted in generic care/minimal specialist care. This has had an impact in geriatric care, for example.

High pressure and intensity of work has left many colleagues fatigued. This, combined with lengthy shifts wearing bulky PPE and dealing with high mortality rates (particularly in geriatric wards) will undoubtedly have an impact on staff wellbeing and mental health. Plans on how to support these staff members will need focus.

Next Steps

A post COVID-19 action plan is in progress, with the aim of it being robust, in order that patients spend the minimum time possible in the acute sector. The discharge to assess model used during COVID-19 ideally needs to be continued to ensure patients are having an optimum assessment.

The community bed offer has been successful and ideally should continue.

Rehabilitation for frail, elderly patients will become essential as a COVID-19 diagnosis can alter their previous needs.

COVID-19 is being included in this year's Winter Planning; management of patients and potential future waves.

Key Learning Points

There is a need for standardisation of systems around discharge due to the complexity of it.

To ensure the system keeps moving forwards, a COVID-19 action plan is required.

Cross system working has been essential and successful. Relationships between the acute hospital, community health, third sector, local authority and Age UK has enabled a smarter way of working and has provided a better understanding surrounding the services and recognition of their barriers.

Interviewee: Dawn Marshall, Leeds Teaching Hospitals.

Local Care Direct: Out-of-hours Urgent Care

With the rapid escalation of COVID-19, it became apparent that there was an urgent priority to assess how out-of-hours urgent care could continue to be accessed by patients in a safe way, whilst minimising infection risks to them and to staff.

Approach/Methodology

Following national guidance to maintain patient safety, there was an urgent requirement to minimise the number of face-to-face appointments and ensure any which occurred were appropriate.

Considerations needed to balance minimising the risk of infection within a health care setting as well as the need to maintain access to these services (e.g. travel) for patients.

Pre-COVID, patients could be directed to a face-to-face appointment, if deemed necessary in a centre or by a home visit, directly and without prior assessment.

COVID-19 accelerated the principal of 'talk before you walk'. This allows assessment prior to confirming the requirement for a face-to-face appointment. Historically, many patients have not required a face-to-face appointment to be safely dealt with.

Changes made to the urgent care/out-of-hours pathway resulted in all cases transferred to Local Care Direct (LCD) by NHS111 being remotely assessed by the West Yorkshire Urgent Care Hub first. This resulted in a 45% reduction in the need for face to face appointments. Remote clinical assessment via telephone or video increased from 52% to 78%, with the closure rate increasing from 42% to 87.5%.

The Hub utilised AccuRx for video consultations, which was well received. After remote assessment, any patient who urgently required a face-to-face appointment was seen, whether COVID-19 symptomatic or not.

Impact

There has been extensive auditing throughout the system where protocols have changed, checking on patient outcomes to ensure no adverse consequences.

To date there is no evidence of any adverse effects from the increased use of remote consultations to reduce face-to-face interactions or the higher rate of closure. The use of video has proved beneficial and also appears to have resulted in a reduction in overall prescribing when compared with pre-Covid levels. COVID-19 has also initiated the use of electronic prescribing, which has proved extremely beneficial in supporting the shift to greater use of remote consultation.

Historically, there has been a challenge in meeting KPI's within the urgent care pathway, with the principal reason being capacity and demand not being aligned. The response to Covid has seen significant additional resource in LCD's hub operation, which has led to the gap between demand and capacity narrowing substantially. Consequently, from May, there has been a substantial improvement in response times for patients.

Challenges

There was conflicting guidance around the correct PPE, which proved problematic at the outset, but LCD followed national guidance throughout.

A wide range of infection control measures were required to address concerns around safety from staff, and there is ongoing risk assessment.

This is important because there are a high number of staff working in the LCD Hub, which plays a key role in the local health system and needed to be maintained throughout. LCD put safety measures in place such as screens, spacing of working positions and strict IPC regimes to protect staff. LCD is conducting a post-incident review which indicates support/positive feedback for the safety measures taken.

Next Steps

A post COVID-19 action plan will be developed from the review and from engagement with partners in West Yorkshire health systems and will define how out-of-hours urgent care will be delivered going forwards. Face-to-face consultations are now increasing again slightly (from 10%–15%) over recent weeks, as the situation resets to the "new normal". However there is still a requirement for as much remote assessment as possible whilst the threat of COVID-19 remains.

Areas for further discussion include the impact of COVID-19 on the ability of LCD to accept direct booking of face-to-face appointments by third parties such as NHS111, as this constrains LCD's ability to control the face-to-face environment and manage patient expectations.

Similarly, at a time when face-to-face responses are constrained by infection control measures, the role of walk-in services such as Urgent Treatment Centres needs to be reviewed to ensure that new ways of working do not result in patients simply taking their problems to the Emergency Department (ED), adding to their workload. LCD and Leeds Hospitals are piloting a scheme where some patient care is transferred from ED to local Urgent Treatment Centres, where this is safe and appropriate, and in accordance with agreed protocols developed jointly by the two organisations.

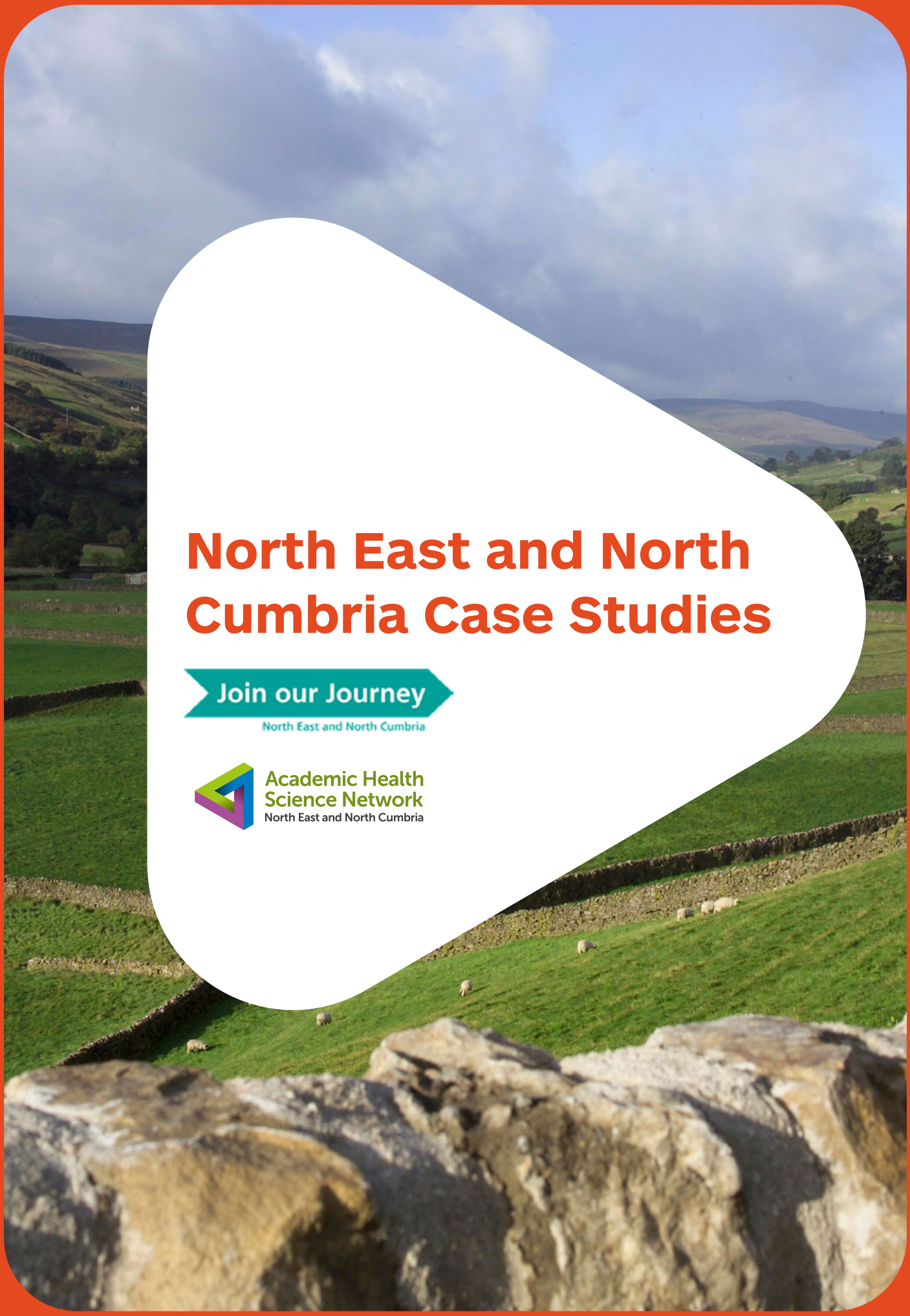
Key Learning Points

The use of major incident mode to manage the organisation's response, and record actions and decisions taken, has been extremely beneficial and supported effective change control.

LCD saw an influx of clinicians during COVID-19, many of whom lacked experience in virtual consultations, resulting in a need for clear guidance and expectations. A COVID-19 weekly bulletin was created as a result, to ensure the whole team were kept informed at all times.

The early establishment of the key principles which would underpin the response to COVID-19 was also key. Chief among these was that patient care had to be maintained appropriately and safely and this needed to be balanced with the requirement to keep staff safe.

Interviewee: Andrew Nutter, Local Care Direct.



North East and North Cumbria Case Studies

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Health Call Digital Care Homes

Health Call Digital Care Home was being implemented in the county, commissioned by Durham County Council, but delivered in partnership with County Durham and Darlington NHS Foundation Trust (CDDFT). However, the pandemic necessitated an increase in implementation pace due to the impact of COVID-19 on care homes.

Approach/Methodology

The Supporting the Provider Market project work involves working with providers of adult social care but also working with provision / services linked to hospital discharge and admission avoidance.

There are five main areas of provider support: recruitment and retention (care academy); training and development (care academy); practice support (proactively looking at areas where support can be given); tech and innovation (including Health Call Digital Care Home); and finally, provider interfaces with health and social care.

When COVID-19 hit, this project placed County Durham in a very good position to build on. They had already identified key development areas and had several initiatives either in place or currently being implemented.

In terms of the Health Call Digital Care Home initiative, which enables electronic referrals and remote monitoring of residents by Older People Care Homes, the pace of implementation was rapidly increased by CDDFT in February, March and April. This meant the project was completed in 14 months instead of 24. Working in partnership, the Health Call offer has been expanded to include remote dietetic support and wound care and also moved into other settings such as Extra Care.

The Council and CDDFT, who already had a good relationship, worked together as a team with local GP Federations and Care Homes. Access to kit proved difficult during the pandemic (e.g. sourcing thermometers, pulse oximeters and tablets) but as procurement and finance processes were streamlined and the Trust were able to help procure kit, this was managed effectively. There was also quicker decision making regarding wider roll out, which supported rapid implementation in new areas.

Impact

The implementation of Health Call Digital Care Homes meant reduced footfall to the homes as remote monitoring was used by clinicians in collaboration with care home staff. Safe decisions could be made

and advice given to care staff who were empowered to be proactive in seeking support for their residents. The residents themselves were able to see care home staff were responding to their needs by taking observations when unwell or as part of the regular observation monitoring. Care Home staff spent less time on the phone making referrals, freeing them up for more time providing direct care.

The care home staff were also able to request COVID testing for symptomatic residents via Health Call Digital Care Home system.

Latest analysis comparing data from November 2018 to August 2019 and November 2019 to August 2020 has found that the number of hospital admissions in Care Homes with Health Call Digital Care Home have reduced from an average of six per care home, per month, to 2.4 per care home, per month.

The success of the system has led to case studies being developed which have been published on the LGA website and will be included in the upcoming CQC Enabling innovation and adoption in health and social care report.

Next Steps

Using this digital system, the care home staff can access the health care support residents need. There are safeguards around pathway requests using the Single Point of Access (SPA).

As the initial idea for this system came from a care home, it is continually being developed and improved in partnership with the homes. Ideas can be suggested and changes implemented.

The council are now working with Learning Disability and Mental Health Care Homes to explore what their needs are for a digital solution to accessing health services when a resident is physically unwell.

The Council have recently offered a Tech Innovation & Improvement Fund for CQC registered care providers to bid for funding such as equipment, software and also ways to improve connectivity.

Key Learning Points

The care homes themselves helped develop and champion the app and shared their experiences with other care homes and support their uptake.

Spread and adoption comes from cross-working with the Council, CCG, Trust, Care Homes and presentations at national and regional events, which are co-produced and delivered with the Trust and care home managers.

Wraparound support should be offered with the system e.g. follow-up/refresher training and IT support.

Funding needs to be provided for long term sustainability.

Confidence has developed amongst users, but lack of confidence should not be underestimated.

Testimonial

“We do it best when we do it together”.

Interviewee: Sarah Douglas, Project Manager for Supporting the Provider Market, Durham County Council.

Mental Health and Wellbeing Support Line and Booklet

NENC ICS knew that Covid-19 was likely to cause negative mental health consequences across the population. However, the help available was generally for those experiencing a mental health crisis and there was less support for those with lower-level wellbeing concerns.

Approach/Methodology

North East and North Cumbria Integrated Care System (NENC ICS) helped to set up a mental health support line. This was done to pick up 111 calls where people have a non-crisis mental health need. This approach was further supported by the ICS suicide prevention work stream, who worked in collaboration with a local charity to produce a mental health and wellbeing booklet during Covid-19, which was delivered to every household in NENC.

The mental health support line was staffed by a group of volunteer clinicians and clinicians who were supported to contribute by their organisation through flexible working arrangements. It took two and a half weeks to implement, including signing off information sharing agreements, setting up infrastructure, and getting the project management team in place.

The mental health and wellbeing booklet, created by Every Life Matters, Cumbria, was delivered to every household in NENC and involved a large amount of system working and support from partners including the Academic Health Science Network North East North Cumbria (AHSN NENC) and the North East Chamber of Commerce, to get it funded, printed and distributed.

The impetus of Covid-19 meant that it was able to be a very quick turnaround, which would not have happened before.

Impact

There were a lot of different places for people to go to receive mental health and wellbeing support, but they were not well known or well publicised and could be difficult to navigate. The mental health support line was able to provide a listening service, offer advice and direct people to these platforms to receive support.

The biggest success that came out of the initial data was how it showed that the support service did not have very many repeat calls. This possibly shows that when people received the intervention they needed early, it reduced the risk of them going into a crisis. The data also showed that it may have been very difficult for people to have received help elsewhere if the mental health support line was not there, as feedback from callers suggested that the support already in place was not easily accessible to members of the public. A full evaluation by Teesside University, funded by AHSN NENC, is in progress and the report will be shared on completion.

Success on the mental health and wellbeing booklet was due to having a 'big ambition' supported by the ICS mental health steering group to get the booklet to every household in the region. It will not possible to predict the mental health impact or who was going to be affected by Covid-19, so this was a way of pre-empting mental health issues that may have arisen by offering practical advice and access to support. The AHSN NENC were a very big help in getting the mental health booklets out there, by negotiating with the print company for the big print run and organising distribution.

Next Steps

NENC ICS want to create a website that brings together all mental health and wellbeing resources available so that people have access to information swiftly and easily and don't have to call in to 111. They are working on this platform and also taking forward discussions to ensure something is in place which provides the level of support and advice that the mental health support line had been providing.

Funding to produce a pocket-sized version of the mental health and wellness booklet and other resources is being progressed. The electronic version has been shared across networks regionally and nationally.

Key Learning Points

The mental health support line did not classify callers as 'patients', which meant the team did not medicalise or pathologise the enquiries. Instead they provided a signposting and listening service. The calls did not go on a clinical record or attempt to create an additional clinical service. Instead they provided a bridge between people who had a mental health need but did not require a mental health service.

The biggest challenges were in the practicalities of setting up the support line. For example, when someone calls into 111 there is a call management process informed by a directory of service. The team had to set up another directory service to accommodate the service role.

For the booklet, the biggest challenge was the logistics of printing and the distribution of the booklet. The aim was also to make sure that it was printed and delivered on time for mental health week, which was a tight time constraint. However, these challenges were managed well by a cohesive team approach.

Overall, it is important to remember that we are here to look after people and, whatever the project, if it's going to help people then it needs to be done. It is important that we don't get caught up in the bureaucratic process and it is vital that the speed of implementation that has been achieved during coronavirus is not lost when we go back to 'business as usual'. The teams involved reflected on the timeline for the projects and indicated that, had we tried to do this before coronavirus, it would have taken months because they would have had to have consulted with lots of groups. It would have been very easy for someone to say no and lose sight of the intention, which was ultimately to help people at a difficult time.

Testimonial

There was a fantastic response to the mental health booklet overall. For anecdotal evidence, Gail's neighbour saw it and said that she had talked about mental health with her family on a zoom call, which they would never have done before. Furthermore, a friend who works for the council told her that it was recirculated through their team manager who said that it was *"one of the best sources of information they have received through the whole Covid-19 period."*

Interviewee: Gail Kay, NENC ICS Programme Director for Mental Health.

Smokefree NHS Programme

NICE guidance PH48 describes using every opportunity for healthcare professionals to raise the topic of smoking, offer treatment and referral to services routinely. The North East North Cumbria (NENC) ICS Smokefree Taskforce aimed for all trusts to be Smokefree by April 2020 through implementing NICE guidance, including assessing the smoking status of people admitted to hospital and providing access to Stop Smoking medication.

The COVID-19 pandemic led to hospital Trusts changing their processes and redeployment of staff to manage pandemic response. This meant that the aims and workstreams of the Smokefree programme were affected during the pandemic.

Approach/Methodology

Trusts are required to include smoking status as part of the clinical assessments for patients being admitted to hospital; this requires brief non-specialised training (Very Brief Advice) for staff, to ensure they can signpost and advise patients when required. Some Trusts have adapted to deliver training virtually via e-learning and Microsoft Teams.

The North East promoted a national 'Quit for COVID' campaign, which promoted the benefits of smoking cessation as the COVID-19 virus was known to cause respiratory issues and evidence suggests that smokers have a greater risk of developing complications if they get COVID-19. The Smokefree NHS Taskforce also launched the 'Don't Wait' campaign, fronted by a local respiratory consultant which, whilst not COVID-specific, included general stop smoking messages such as 'it's never too late' and 'there has never been a better time to quit'.

Impact

The height of the pandemic led to the smoking status questions being removed in some Trusts to speed up the assessment processes; these have since been reintroduced. This impacted provision and referrals for ongoing support. Provision of medication and support to quit was also impacted by the reduction in footfall across Secondary Care.

The Mental Health Trusts in the region had fewer opportunities for patients to leave the facilities as part of the infection control measures. This led to fewer opportunities

for patients to access supplies for e-cigarettes which led to some struggling to manage their withdrawal symptoms.

Feedback from the YouGov survey in July indicates that in the North East region, quit attempts were double that of other regions.

Next Steps

The e-learning programme 'Tobacco and Alcohol Brief Interventions' is being promoted to ensure staff continue to be trained on smoking interventions and providing advice to patients.

Some hospital Trusts have identified champions to support dissemination of information to staff on the wards.

The Smokefree NHS Taskforce have developed a regional dataset for Trusts to report the number of patients smoking status' screened, given advice/medication, etc. on a quarterly basis, to monitor progress across the region as work continues towards implementing the NHS Long Term Plan.

Key Learning Points

The programme is aiming to change the culture and attitudes towards smokers, promoting the view that smoking is a long-term chronic condition, and we need to work with patients to treat their addiction with nicotine management.

Trust Stop Smoking Leads continue to meet remotely. They feel this works well and across the large region it is more time effective, so it has been proposed that this continues.

Interviewee: Joanna Feeney, Smoke free NHS Programme Manager, NENC ICS.

Using Video Consultations for Autism First Assessments

The diagnosis of Autism in children requires observation of the child and interviews with parents. The COVID-19 pandemic led to these observations and interviews being conducted virtually instead of face-to-face.

Approach/Methodology

Newcastle Upon Tyne Hospitals (NuTH) use the Starleaf Platform for virtual consultations and the team checked with the Trust's internal governance to ensure it was appropriate for the intended use. Once approved, the team approached families to opt into the virtual assessment process.

Information was provided to families regarding the modified observations and instructions on how to use the Starleaf app.

After diagnosis, speech and language sessions were run via video. The North East Autistic Society (NE-AS) have also been running webinars on an introduction to Autism, emotional wellbeing and behavioural advice.

Impact

The team were able to make a diagnosis over video of autism or another developmental disorder in 34/48 (71%) of children assessed.

Staff found being able to assess the child in their own home provided some insights they didn't always get when assessing in the hospital setting. E.g. seeing their toys and behaviour in a familiar setting.

The team found that sometimes by using the video assessment, the interview and observation could be done at the same time, on a single session.

A family survey was completed with 28/48 families who accessed video assessments. Twenty families felt that the communication with them was the same (16) or better (5) over video. Twenty families felt the experience for their child was the same (11) or better (9) over video than it would have been at the hospital.

Comments on the advantages included not having to take time off work or arrange childcare for other children, or prolonging the long waiting time for assessment even more. Some expressed frustration with the technology, forgetting to ask things, or expressed a preference for face-to-face contact.

Next Steps

The team would like to continue with a blended approach of both video and face-to-face assessments. Video assessments are not wanted or are not accessible to some families. There are some children whose diagnosis is more complex and need additional face-to-face assessments to agree a diagnosis.

The team regularly use interpreters during face-to-face assessments and are going to trial using them during the video assessments. This presents new challenges for the team as it has not been attempted before.

The team are applying for funding to support the continuation of the NE-AS webinars which have been viewed as invaluable during this period. They are also looking to produce some professional videos about common post-diagnostic issues and adding subtitles.

Key Learning Points

Initial attempts at scheduling by next on the waiting list led to missed appointments and we moved to an opt-in system. Some families were unfamiliar with logging in to video calls and it was realised they needed to provide more instructions to families. We also provided clearer information about items they may need for the assessment, such as specific toys.

This process is likely to have widened health inequalities as families without access to devices or the internet, or who need an interpreter, have, so far, not been able to access video consultations.

Interviewee: Helen Leonard, Paediatric Consultant, Newcastle Upon Tyne Hospitals.

Yorkshire & Humber AHSN

Website: **yhahsn.org.uk**

Email: **info@yhahsn.com**

Address: **Yorkshire & Humber AHSN**
Unit 1, Calder Close
Calder Park
Wakefield
WF4 3BA

Telephone: **01924 664 506**

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