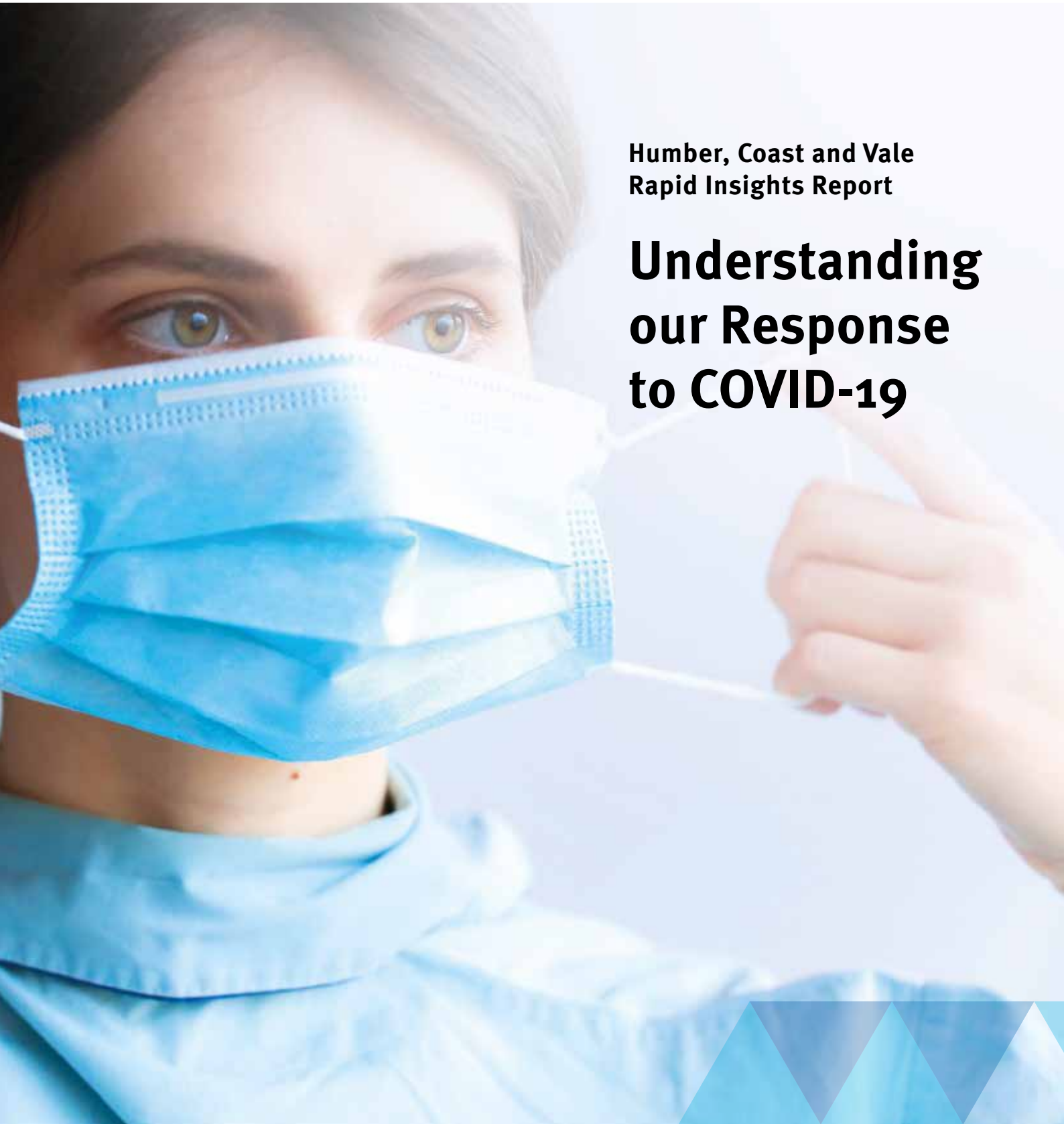
Humber, Coast and Vale

Yorkshire & Humber AHSN



Humber, Coast and Vale
Rapid Insights Report

Understanding our Response to COVID-19





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Foreword

We believe that our communities will benefit for many years to come if we can learn from the changes made in response to the COVID-19 pandemic. The UK's health and social care system 'as we knew it' is unlikely to be seen again, and as we start to emerge and recover from the pandemic we will be faced with a 'new norm'.

Humber, Coast and Vale Health and Care Partnership (HCV Partnership) and The Yorkshire & Humber Academic Health Science Network (YHAHSN) have been working closely together to gather information on and evaluate the impact of innovations and the creative ways the system has adapted services in response to COVID-19 and supported its local populations. We wanted to understand more about these changes in order to recognise how they could continue to provide the quality of care required and improve the health and well-being of our population

It has been clear to see that we have prioritised the safety of patients and staff, and there is a commitment amongst colleagues to provide the best possible service to patients and clients within the restrictions and challenges that COVID-19 has brought.

We will continue to support service improvements and innovations, and the evaluation of the COVID-19 response changes will be a key part of the broader phase three plans in HCV as we look to rebuild and reset our health and care system.

For more information on the Learning from COVID-19 - Capture and Evaluation Programme please contact the HCV Partnership Team on hullccg.hcvstppmo@nhs.net or the YHAHSN Programme Team on info@yhahsn.com.

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1. Introduction

At the height of the COVID-19 pandemic, a large number of rapid changes and service improvements were made to working practices. Changes that would have previously taken at least a few months to design and implement have been accomplished in days or weeks. The changes and service improvements were made to ensure across Humber, Coast and Vale, our organisations could continue to deliver quality health and care services in a safe manner for patients, service users and staff, during these difficult times.

The speed and scale of the changes and service improvements made is difficult to track and document them and evaluate their impact. Therefore, across Humber, Coast and Vale Health and Care Partnership (HCV Partnership) we were keen to take the opportunity to assess the practicality and effects of the new working practices and to identify, refine and embed those which have delivered real benefits.

Therefore, a piece of work was initiated by the HCV Partnership Clinical and Professional Group to do a rapid capture and evaluation of the changes and service improvements that had been made in response to COVID-19.

To support the rapid evaluation and learning, the HCV Partnership has been supported by and worked alongside the Yorkshire & Humber Academic Health Science Network (AHSN) to review and analyse the results of the information capture and develop a number of initial case studies through interviews and facilitated discussions, to help generate insights into the learning from the impact of COVID-19 on delivery of our health and care services.

This report presents the findings from this work to support partners across the HCV Partnership to learn from the changes that have been made, to embed the positive aspects of change and to understand further considerations or potential risks to inform plans for the future of health and care services across Humber, Coast and Vale.

We have in the first few pages provided an overview of the key messages from the work with the detail captured in the appendices for those who wish to learn more about specific areas.

2. Approach and Methodology to Service Improvement Capture and Evaluation

The objectives for the rapid capture and evaluation of innovation and transformation resulting from responses to COVID-19 aimed to ensure that:

- **The recent service changes and improvements were recorded and promoted**
- **That the new and improved ways of working are embedded**
- **That the lessons are learned, with changes and improvements assessed to recognise the impact (intended and unintended).**

To support the delivery of the objectives a set of principles were established to support the information capture and evaluation to ensure that the approach taken was as inclusive and wide ranging as possible and that where it was available, the information provided was evidenced based. We also recognised that we were undertaking this piece of work as we continued to respond to the COVID-19 pandemic, therefore we recognise that we may not have captured everything in this initial rapid piece of work.

The scope of the changes and service improvements spanned the entirety of the HCV Partnership, therefore the information capture was designed to cover:

- **All of the Health and Care sectors**
- **Clinical and Non-Clinical elements**
- **Organisations and Geographical (e.g. Place, Humber and North Yorkshire) aspects**
- **Transformation Programmes (Humber, Coast and Vale Collaborative Programmes).**

The process adopted was based on an appreciative inquiry-based approach and it was operated on the basis of being respectful and understanding of the operational and clinical pressures faced by colleagues across the system. Therefore, mixed methods were used to capture information including:

- **Surveys (templates and an online form submissions)**
- **Semi-structured interviews**
- **Facilitated sessions**
- **Assessment of evidence provided in a variety of formats**
- **Secondary research including public and patient engagement feedback.**

Research Limitations

This research aims to capture a broad range of experiences in a limited time. It must be viewed in context of the breadth of the partnership and is not intended to be fully comprehensive. It should be viewed as the initial phase to inform future research.

3. How Services Have Changed in Response to COVID-19

More than 330 examples of changes and service improvements across Humber, Coast and Vale were identified through the initial request for information that was circulated to organisations, individuals and teams across the health and care sector.

Categorised Themes

There were recurring themes within the submissions and in many cases a number of primary and secondary, clinical and non-clinical reasons for why the changes could be identified.

From the information received, seven broad "themes" were identified against which the changes and service improvements have been grouped. For each of these themes the following questions have been explored:

I. What have been the key changes?
II. What were the reasons for the change?
III. What were the keys to successful implementation?
IV. What have been the benefits of the changes?
V. What are some of the considerations in this area going forward?

The findings and greater detail on each of these themes can be found in Appendix I: 'Overview of Key Learning in Categorised Themes' however, in summary the categorised themes cover:

1. **Advice, Guidance, Referral and Triage:** The need to reduce face to face interactions to keep staff and patients led to the implementation of referral assessment systems and triage processes. This has led to increased capacity, greater collaborative working and a reduction in patient anxiety.
2. **Discharge**: The Discharge to Assess Model has enabled an increased capacity in acute hospitals has been positively received by patients and staff but considerations are needed around funding streams and the maintenance of community beds to maintain this process.
3. **Patient Care**: The need to reduce hospital footfall and patient anxiety led to the changes in patient care. This has enabled good collaboration between partners and creation of responsive services for patients.
4. **Use of Technology**: Technology has enabled staff to continue to care for patients even while shielding / isolating. COVID-19 was a common challenge which reduced resistance from patients and staff, however considerations are needed around capability and access to technology for both staff and patients.
5. **Workforce**: Redeployment of staff, reduced capacity and increased demand has affected staff wellbeing and resilience. Organisations across HCV have been working hard to support staff welfare and wellbeing.
6. **Pandemic Response**: Staff attitudes and availability of technology have enabled staff and services to change in response to COVID-19, but considerations are needed around how we balance changes made as a pandemic response with delivery of services as part of routine delivery. 78
7. **Other**: COVID-19 has enabled virtual change, and the utilisation of third and voluntary sectors has supported community and care sectors. Funding and evidence to establish the effect of the changes need to be considered.

3. How Services Have Changed in Response to COVID-19

To support these broad themes, we have also gathered some information on the key changes and developed case studies to help support learning, spread and adoption. The case studies were developed with the engagement of representation from across Humber, Coast and Vale and cover various aspects of health and care. These can be found in Appendix II: 'Case Studies' and including the following:

- **Primary Care Total Triage at Haxby Group**
- **24/7 COVID-19 Mental Health Support in North East Lincolnshire**
- **Dental Pre-Appointment Communications in Hull**
- **Video Conferencing and Consultation in Care Homes**
- **Jean Bishop Integrated Care Centre; Community Frailty Support Team- Hull and East Riding**
- **Rapid Discharge Process- York and North Yorkshire Control Room**
- **Delivery of Pulmonary Rehabilitation Services across Humber, Coast and Vale**
    1. Pulmonary Rehabilitation by York Teaching Hospitals and Humber Teaching Hospital
    2. Care Plus Group delivery of Pulmonary Rehabilitation using Zoom
    3. Virtual Reality Pulmonary Rehabilitation Pilot in North Lincolnshire
- **The 'Ask a Midwife' Service**
- **Virtual Parent Classes**

Deeper Rapid Insight of Key Themes

As we have hopefully already demonstrated the information captured on changes and transformation provided a tremendous insight into the large amount of work undertaken from across Humber, Coast and Vale across all aspects of health and care. We were keen to understand in more detail how specific services have been affected through the COVID-19 pandemic and what innovations / transformations they adopted to continue delivering care to their patients.

The three clinical themes identified for further evaluation were:

1. **Respiratory**
2. **Maternity**
3. **Outpatients**

The detail on these three clinical themes can be found in **Appendix III: 'Deeper Rapid Insight of Key Themes'**.

In addition to the three clinical themes we also engaged in a regional Primary Care Digital learning exercise. This exercise was aimed at understanding which digital tools were adopted by primary care and how staff were feeling around implementation.

Across Humber, Coast and Vale the two most adopted online consultation tools were Engage Consult and e-Consult. In most cases (76%) these are being used as an additional engagement method. The reasons given by those who had not implemented online consultations were related to workforce capabilities and demand management.

AccuRx has also been used throughout Humber, Coast and Vale for video consultations with patients and those who have used it have had a positive experience. The majority (98%) of GP practices who responded employ a phone first approach before video consultations. AccuRx is also being used to engage with care homes alongside other technologies such as Teams and Zoom.

SMS messaging to contact patients is being widely used. By using SMS messaging for patient reminders, clinical messages and bulk messaging GP Practices experienced a reduction or significant reduction in workload.

For both video conferencing and SMS messaging it was felt that they were useful tools for pandemic response and future service delivery.

There were also comments made by the clinicians who responded that they felt that the decisions they were making during the pandemic had greater risk however, the digital tools implemented supported them to mitigate these risks. There is also the expectation that these tools will remain effective once primary care delivery returns to the 'new normal'.

Greater detail on the primary care digital learning is set out in the 'Rapid Insights into Digital GP Solutions during the COVID-19 Pandemic' report, embedded as Appendix IV: Primary Care Digital Learning.

Enabling the Change

Based on the work provided throughout this rapid insight process, it became apparent there were a number of **enabling factors to making change happen** including:

- **Effective communication**
- **Collaborative working**
- **Embracing technology**
- **Agility of decision-making / removing bureaucracy**
- **Changes in behaviour / attitudes**

Through the analysis of the information and the facilitated discussions behaviour change in management and in front line staff as well as in the change of behaviour of patients were cited as a key reason for the successful implementation of the change. The willingness by all to innovate, cooperate with change and collaborate between and within teams across the system, as well as share knowledge has resulted in increased productivity and quality health and care services in a safe manner for patients, service users and staff, during these difficult times.

Staff have acknowledged that they have felt empowered to make rapid decisions and implement change with the removal of bureaucracy, and there have been an increased appreciation of the role of the voluntary sector. Patients have also shown a willingness to self-manage conditions and embrace technology during this period. However, we do recognise that particularly for service users / patients there is a possible increased risk of harm as some have been frightened to access services.

Rapid changes and flexibility in the deployment of staff, due to reduced capacity and increased demand have supported revised and streamlined health and care pathways for cohorts of patients and service users. A lot of the changes made have been as a result of embracing technology, particularly the adoption of remote triaging and where data sharing agreements have rapidly been put in place. Strong communication to both staff and patients around the changes made and impact enabled new processes to be understood and adhered to.

The increased availability of technology throughout the Partnership has enabled remote working. Staff have utilised technology such as Microsoft Teams to conduct virtual meetings and MDTs. As well as improving productivity, the reduction in travel to meetings across the region has had a positive impact on the region's carbon footprint. Patient needs have continued to be efficiently met with the use of telephone and video consultations (utilising technology such as AccuRx) to reduce face to face appointments.

4. How COVID-19 has affected Patients and the Public

Information from external reports and complimentary literature produced by organisations across Humber, Coast and Vale were also collated to provide insight into particular services or opinions of the public on their general experience of healthcare during COVID-19. These reports were created independently of the Learning From COVID-19 programme, however they are all link to the rapid insights work and highlight the experiences patients and the wider general public's experience of COVID-19.

The reports and surveys were conducted over various timeframes, beginning after lockdown came into effect in March 2020 until June 2020 and cover a broad geographical and health and care sector spectrum of Humber, Coast and Vale.

The details on key findings these patient and public engagement reports have identified are in Appendix V: 'Patient and Public Engagement Feedback'. The identified themes are summarised below:

1. **Communications**: The experience of care was improved where people received regular information however a lack of clarity and consistency can sometimes lead to public confusion.
2. **Vulnerable and Protected Groups:** People were still able to access the care they needed but access to other services such as carer respite was more challenging, as were access to information in formats such as easy read and in other languages.
3. **Access to Healthcare**: People generally have had a positive experience with healthcare services during COVID-19 however there were some challenges identified with transportation services and communication around changes to appointments.
4. **Mental Health**: Digital tools were used to support some service users with their mental health which was seen as positive however those on waiting lists have experienced delays accessing services and some support such as crisis support were not always accessible.
5. **Digital Changes and Innovation**: Respondents felt safe using digital consultation tools due to lower infection risks however some tools in use are not the most user friendly. More rural areas of the region also struggled with connectivity.
6. **Patient Safety**: Training and expertise of care home staff as well as access to care for those living in their own homes were the main concerns raised by respondents. There were also fears raised around infection risk while attending regular GP and hospital appointments.
7. **Social Care**: Where they could, people supported their vulnerable family members with care. Support was still provided to the majority of people who needed it, however some care and support was stopped or reduced which left people struggling with daily tasks.
8. **System Working**: The third and voluntary sectors are valuable to the system and when they are unable to provide their usual level of support, bottlenecks can form in the system.
9. **Wellbeing**: Public support packages had to be developed based on individual circumstances. Access to social media has helped people stay in contact but it can lead to negative feelings due to comparisons with others.

There are some limitations to be aware of when reviewing this information which include that York is generally overrepresented in comparison to other areas, and that there is limited information on the experiences of protected groups such as the black and minority ethnic population.

5. Conclusion and Next Steps

A vast quantity and range of data has been collated from across the HCV Partnership to demonstrate the innovations and transformations that have been implemented in health and care services in response to the challenges presented by COVID-19. There is a desire to capture this learning in order to sustain these changes in working practices and to identify any barriers that will prevent these changes from being maintained.

To sustain the changes and maintain the progress made through the response to COVID-19 there are a number of areas that Partners and Organisations across the Partnership will need to consider including, but not limited to:

- **Finances to sustain changes**
- **Discrepancy in IT access and knowledge – connectivity and digital exclusion**
- **Patient data sharing – the need to create a single information governance regime and secure interoperability**
- **Patient safety and mental health**
- **Communications with vulnerable and protected groups**
- **Prioritisation of social care sector**

COVID-19 meant that there was an urgency to introduce new ways of working and adopt technology because people realised the need to do this and resistance to change diminished. The pandemic was the common challenge that accelerated change and broke down barriers. Systems already transforming services were able to adopt new ways of working more quickly as there was an infrastructure in place.

Next Steps

As we look to rebuild and reset our health and care system, we need to ensure that the learning from the COVID-19 response is shared, adopted and adapted where appropriate to enable us to continue to deliver quality health and care services that are safe for our population.

To do this we have set out below a number of recommendations in relation to next steps. These are that:

- The report is circulated across the HCV Partnership to inform the development and implementation of phase three plans and support the embedding of change and service improvements
- Whilst we encourage everyone to review the learning, for specific themes we have identified the following owners in existing programmes or arrangements where we felt specific elements of the report should be considered:

Theme from the Report	HCV Programme or Arrangement
Advice and Guidance, Triage and Referral	Planned Care, Primary Care and Geographical Partnerships
Discharge	Urgent and Emergency Care, Geographical Partnerships and Community Collaborative
Patient Care	Acute Collaborative and Primary Care
Use of Technology	Digital
Workforce	Workforce
Pandemic Response and Other	All
Respiratory	Planned Care
Outpatients	2 Care
Maternity	Local Maternity Support

- HCV Partnership will use this report to identify priority areas they wish to understand further around the impact of changes made during COVID-19.
- We will engage with key groups involved in these priority areas for further evaluation.
- Longer term, the HCV Partnership will work with YHAHSN to utilise a QI sustainability approach to embed key changes and transformation initiatives across the region.

Acknowledgements

We want to thank everyone across Humber, Coast and Vale for their hard work, enthusiasm and ingenuity over recent months in responding to the COVID-19 pandemic. The examples which were submitted provided valuable insights into how the system reacted to the pandemic and we appreciate the additional time that has been given to provide the contributions that have supported the development of such rich information.

Finally, we want to acknowledge work of the small team from the HCV Partnership and YHAHSN for managing the process and collating the information for this report.

Policy Context and Governance

The Yorkshire & Humber AHSN have led the coordination of the regional activity in partnership with the NHS England and Improvement regional team and the work we have undertaken has been aligned to the phases of the NHSEI response to COVID-19.

All activity undertaken through this evaluation exercise has been monitored and managed through a HCV Partnership weekly steering group reporting into the HCV Partnership Clinical and Professional Group and other forums as required / requested.

Appendix I: Overview of Key Learning in Categorised Themes

- **Advice, Guidance, Referral and Triage**
- **Discharge**
- **Pandemic Response**
- **Patient Care**
- **Use of Technology**
- **Workforce**
- **Other**

Advice, Guidance, Referral and Triage

What Have the Key Changes Been?

1. **Referral Assessment Systems (RAS)** to support the rapid screening and triaging of patients across the region. For example, in North Lincolnshire, urgent or two week wait GP Referrals, were submitted via an e-referral system to the hospital trust to be triaged / screened by a specialty clinician.
2. **Telephone triage and assessment**, which has been used across the region, such as in the Early Pregnancy Assessment Unit where women were not expected to attend the unit without a telephone triage consultation with an experienced clinician to prioritise those at high risk of complications.
3. **Advice and guidance helplines for healthcare professionals**, for example in Hull where several services have introduced access to advice and guidance where it previously was not available, including Vascular, Colorectal and Paediatric Medicine.
4. **Relocation of some services**, for example, the diversion of emergency ophthalmology referrals from acute care to community in York.

What Were the Reasons for Change?

1. It was necessary to reduce the number of people physically attending appointments to **ensure that social distancing measures could take place**.
2. There was a need to **reduce face to face appointments for vulnerable groups**, for example for pregnant women who were considered high risk.
3. It was important to continue to **deliver services safely for both patients and staff**.

What Were the Keys to Successful Implementation?

1. **Increased engagement and enthusiasm for change from staff**. For example, in the initial pathway triage of outpatients in Hull, clinicians had to be willing to change work rotas to undertake the triage, and accept the possibility that the initial outcome of the triage processes may involve patients being referred back to primary care.
2. **Acceptance of changes of procedures from patients**, as well as motivation for complying with those changes. Reports from GP practices, for example, suggest a general acknowledgment and understanding from patients that they will have to explain their need before accessing an appointment, a mindset shift only brought about by the pandemic.
3. **Available IT infrastructure**, including the ability to remotely access information, such as patient data.
4. **Clear, unifying, and supportive leadership** throughout the system.

Appendix I: Overview of Key Learning in Categorised Themes

What Have Been the Benefits of the Changes?

In many cases it is too early to understand the full benefits of the changes. However, initial findings can be summarised as follows:

1. **Increased capacity and efficiency** through the thorough revision of patient pathways, meaning a reduction in unnecessary appointments and improved patient management.
2. A subsequent **reduction in referrals** to secondary care, for example, in cases where GPs were motivated to uptake the advice and guidance available, some conditions were able to be managed at primary level. In the Hull Integrated Care Centre – Community Frailty Support Team there has been a reduction in inappropriate admissions to hospital as a direct result of the changes.
3. **Reduction in patient anxiety** as they can access services flexibly and overall response time has improved due to the more efficient triage processes. For example, in the Virtual Trauma Clinics, only positive feedback from patients had been received following the implementation of the revised pathways, which included specific reference to increased flexibility in service hours and appointments with the nursing team.
4. **Greater collaborative working** across sectors and between primary and secondary care.
5. **Greater volume and detail of data captured** by the system, which provides opportunities for data-driven, intelligent patient care going forward. For example, Primary Care Total Triage by the Haxby Group, covering patients in Hull and York, has enabled the collection of data that informs and assists triage decisions but could also be used going forward to inform future innovation.

What are Some Considerations in This Area Going Forward?

1. **How any changes to advice and guidance, triage and referral systems can be maintained** when and if the referrals increase.
2. If advice and guidance is to continue at the current levels or greater, then consideration should be given to **how this can be provided in a timely manner**.
3. A need to **consider engagement and communication with the public** over the changes to services to ensure they are meeting need, addressing any inequalities and not increasing them (such as through greater use of technology) and building confidence in the public so they feel they can return to using services.
4. Whether the **quality of service can be maintained**. **Remote consultations are not substitutes for face to face appointments** but can be an addition. For example, in the management of patients with swallowing difficulties in care homes, video consultations could not pick up subtler signs such as shortness of breath, and may miss the wider information available on a face to face visit.
5. **Should two week wait patients be excluded from RAS** as this adds an extra step in the process and possibly a delay in care.

Discharge

What Have the Key Changes Been?

1. The **Discharge to Assess** model has been established to allow for assessment of continuing patient need to take place in the community, rather than on the ward.
2. Establishment of **two-hour discharge** from being declared medically fit.
3. Introduction of **Trusted Assessor Model** to include social services.
4. A **COVID-19 patient monitoring hub** in York that receives referrals from multiple sources, including GPs, NHS 111 and hospitals. The hub's understanding of local voluntary sectors places a safety net of regular calls and assistance around each patient.

What Were the Reasons for Change?

1. A **reduction in hospital capacity** and a need to defer resource to COVID-19 admissions.
2. York's Discharge Steering Group observed that 15-25% of adult acute beds were occupied by patients assessed as not needing acute care. There was an urgent need to address this and **reduce acute capacity**.

What Were the Keys to Successful Implementation?

1. Changes in legislation allowed for **more streamlined discharge pathways to be established** such as the discharge to assess model.
2. The **increased availability of community beds**, and **the increased funding** for those beds, allowed for rapid and safe discharge from acute setting, as well as providing a space necessary for post-discharge assessment to take place.
3. A **desire from patients** not be in hospital supported their early discharge, and conversely the **enthusiasm from staff** to discharge patients.
4. **Strong clinical leadership** to maintain a consistent approach across the region, as well as experienced leadership and support at CCG level.

What Have Been the Benefits of the Changes?

1. The changes created **increased bed capacity** across the region by improving patient flow.
2. Assessment on discharge has reduced delays in discharging patients whilst also allowing patients to be assessed in a more appropriate environment. It is suggested that doing this **reduces the number of false positive eligibility decisions**, as patients can present differently in an acute setting.
3. **Positive feedback from patients**, since there were less delays, and an increase in the number of patients who could safely return home.

What are Some Considerations in This Area Going Forward?

1. **Whether discharge on the day of notification is appropriate**. There is a suggestion to work towards a model of discharging patients on the same day when they are notified to the discharge before 14:00 and by 12:00 the next if notified later.
2. There is desire in the system to **continue the discharge to assess model** but it needs evaluation.
3. When the temporary COVID-19 legislation is reversed, **social care choice will be a factor again** and will have an impact on patient flow.
4. How do we **continue funding additional community beds**, which is currently under the COVID-19 funding streams.
5. The **funding arrangements for new packages of care** after August are not known at the time of writing.

Appendix I: Overview of Key Learning in Categorised Themes

Patient Care

What Have the Key Changes Been?

1. The **COVID-19 response dashboard** captures data on key elements of service provision to enable rapid, informed decisions.
2. **Relocation of services.** For example, the movement of phlebotomy and fracture staff to reduce patient movement within the hospitals and improve patient flow.
3. **An increased number of Advanced Care Plans** on the advanced care plan e-system. One GP Group increased the number of ACPs from 3 to 600 by using administration staff to help collate the information.
4. The establishment of a **24/7 COVID-19 specific crisis line** offering a multi-agency, single point of access.
5. An increased number of **voluntary sector supporters** to help with the greater demand on resource.

What Were the Reasons for Change?

1. **Closures to local authority buildings** and **reducing capacity of hospital grounds** to put in place social distancing measures.
2. The need to **reduce the footfall on-site** to for infection control measures.
3. The **increase in volume of telephone enquiries** from patients in some departments who were seeking reassurance or information from site-specific teams.
4. The necessity to **continue services wherever possible** by adapting the provision of those services to meet ongoing patient needs.

What Were the Keys to Successful Implementation?

1. A **sense of community and collaborative working** across partnerships, for example, with patient-initiated follow-ups, it was necessary to have cohesive working practices between primary and secondary care in the event of patient discharge.
2. A greater **engagement from staff** and willingness to try new ways of working led to a greater 'perception of need' motivated engagement.
3. The available **technology to support the new changes.**

What Have Been the Benefits of the Changes?

In many cases it is too early to understand the full benefits of the changes. However, initial findings can be summarised as follows:

1. A **reduction in social isolation**.
2. **Quicker response time** for patients due to the effective triage of calls, which has increased patient satisfaction.
3. **Reduced footfall in hospitals** and removal of unnecessary appointments.
4. **Improved collaboration between partners**, for example, St Andrew's Hospice's increased involvement with care homes in building relationships and awareness of hospice services, as well as with the wider health and social care sector.
5. **Improved systems to capture demand and capacity planning**, as in the case of the COVID-19 response dashboard, where activity changes are tracked and benchmarked against the same period last year.

What are Some Considerations in This Area Going Forward?

1. More **quantitative data is required** going forward to assess the impact of the measures taken, such as the COVID-19 response dashboard.
2. Consideration needs to be given to **how much remote nurse follow-up can be done** and how this can be supported with an education programme to advocate health and wellbeing initiatives to identify early signs of relapse.
3. **Patients who struggle with the new technology should be identified** and supported appropriately.

Technology

What Have the Key Changes Been?

1. **Remote consultations using video and phone** throughout the health and care system.
2. **Remote monitoring and diagnosis** of patients to support the triage and consultation process and reduce footfall through outpatient departments. For example, image transferring in Dermatology and Plastics Departments to rapidly diagnose some conditions.
3. Remote use of technology by **staff to continue services whilst working remotely,** including telephone triaging and greater adoption of the Electronic Prescription Service.
4. **Virtual communications between staff**, including holding video committee meetings, delivering staff training, virtual MDTs and virtual inductions for new staff using technology such as Go To Meeting and Microsoft Teams. This has improved system working and data / record sharing.
5. **Use of technology to improve communications with patients and families.** For example, the use of technology in care homes in Hull to allow residents to connect with families. Hull also have a website to provide information for young people, parents and professionals on mental health and emotional wellbeing.

What Were the Reasons for Change?

1. To ensure organisations met their **statutory duties** or because of a new request from the **government or NHSE**.
2. To **support patients remotely** during COVID-19 and to continue to **deliver services** wherever possible, despite a reduction in capacity and resource.
3. To support **remote working** during the pandemic and allow staff to continue working while socially isolating.
4. To **reduce footfall** on-site to ensure that **social distancing** measures could take place.
5. To support health professionals to **access up to date patient information** to safely and effectively support patients.
6. To **reduce patients' anxiety** around continuation of their care or reduce isolation by providing contact to friends and families.

What Were the Keys to Successful Implementation?

1. There was an **urgency to introduce new ways of working and adopt technology**, this urgency reduced resistance with both staff and patients. Change was easiest when plans had already been made pre-COVID-19.
2. **Patients were using new communications technologies in their day-to-day lives** more often because of social distancing, which meant that they were more comfortable with video / phone consultations than they were before COVID-19.
3. **COVID-19 was a common challenge** that all organisations faced and so increased system working, and data / record sharing became more possible and the technology to do so improved.
4. The increased use of technology by teams was due to the **funding opportunity COVID-19 provided** to purchase technology such as laptops and tablets.
5. Before COVID-19, the **daily pressures of running services** meant there was no time to plan / implement a wide-ranging review of processes and practices, with regards to technology. COVID-19 enabled new changes to be made.

Appendix I: Overview of Key Learning in Categorised Themes

What Have Been the Benefits of the Changes?

1. Remote consultations and monitoring have **reduced face-to-face** interactions whilst **maintaining services and communications** with patients. Increased telephone and virtual appointments free up time for patients and clinicians allowing face to face appointment times for people who require this intervention.
2. New technologies have **reduced costs and increased the time available for staff to treat patients**. By using AccuRx in conjunction with SystmOne, Hull has reduced admin time, duplication of tasks and the capacity for errors in clinical records.
3. Increased system working, due in part to technology, has increased the **opportunity for knowledge sharing**. The Hull and East Riding Clinical Chair Webinar led to greater information flow and greater clarity as to how and why decisions have been reached.
4. Virtual staff meetings were found to be **more productive**, had **shorter agendas** and **more focus**. They have **reduced the cost of traveling and their carbon footprint**. "Staff have not had to travel to venues for MDT meetings but still able to participate therefore saving time to allow clinicians to undertake clinical duties; a reduction in the number of physical patient case notes… making better use of electronic letters / results etc. during the meeting… No patients' management decisions have been hindered by the meetings not going ahead in the conventional way."
5. **Remote working has led to better working experience for staff**. Sickness rates have decreased and there is an improved work / life balance.

What are Some Considerations in This Area Going Forward?

1. Concern that the adoption and use of technology may **reduce once the COVID-19 crisis is over** and the **old, less efficient ways of working will be readopted**. Hull particularly wants the new digital imaging system to stay going forward and be embraced by primary care colleagues for Plastics and Dermatology Services.
2. **More finance and resources** are needed to fully embed new technologies. Additional phone lines would allow multiple service interventions, such as non-medical prescribing clinics and low intensity wellbeing appointments, to run at the same time.
3. The **needs of patients that do not have access to technology or lack the capability to use technology** are at risk of being left behind and services need to consider how we support these people.
4. There is a **balance between working remotely and working on-site** that needs to be agreed between staff.
5. A **full assessment is required to assess the full impact** of remote consultations.
6. It will **require proactive steps to maintain system working** and data sharing.

Workforce

What Have the Key Changes Been?

1. **Increased staff well-being support** including collaboration between Occupational Health, OD, clinical psychologists and chaplains to ensure that staff have access to enhanced levels of support. Break-out rooms and areas for staff to relax were created and manned by OD, psychologists and coaches. Gifts and donations were distributed to wards who would not normally receive gifts to maintain morale.
2. **7-day working** has been introduced, for example in in-patient services where there was no reduction in staffing or support services at weekends.
3. **Restructuring of teams, redeployment and upskilling of staff in response to need.** For example, a change in the Communications Team included one team member permanently being based in silver command, whilst one team member dedicated their role to managing the influx in donations to their Trust.
4. **Large scale recruitment** included progressing the Central Bank Model, which included a full skills assessment, and expanded to include nursing and conditions bank.
5. A drive for more **volunteer staff**, including volunteer drivers to support delivering PPE and other equipment between sites.

What Were the Reasons for Change?

1. **Reduced capacity and increased demands in certain areas** meant that staffing structures needed to rapidly be addressed. For example, pressures on community services increased with more palliative and end-of-life care, whilst at the same time staffing numbers decreased due to isolation or shielding.
2. There was generally an **increased likelihood in the number of staff requiring psychological support**, due to the difficult clinical situations staff were facing, as well as the increased likelihood of disrupted home lives themselves.

What Were the Keys to Successful Implementation?

1. **Positive attitudes from staff** – an overall acceptance of the need to be flexible in the working conditions and a general 'can do' attitude.
2. A mutual understanding and respect for different organisation pressures / priorities have **motivated teams to pull together**. For example, in North Yorkshire, hospital therapists began working within community therapy teams to provide extra capacity.
3. **Having access to the necessary technology** was something widely reported as being essential. For example, in Hull members of the communications team were able to communicate effectively using Zoom or email while being geographically dispersed.

What Have Been the Benefits of the Changes?

1. **Staff have felt well supported** and responded positively to the available wellbeing services as they had easier access to support.
2. The agile response from the workforce allowed for **a flexible and timely response to patient care and provision.**
3. With the redeployment of staff, there has been **increased shared understanding of job roles**, for example, outpatient staff gained a better understanding of the pressures faced on the wards.
4. The requirement for rapid change has necessitated a **reduction in bureaucracy and encouraged creative problem solving**.
5. Some respondents suggested that with the increased virtual meetings, **staff morale had improved**.

What are Some Considerations in This Area Going Forward?

1. **Ensure that care homes have access to the necessary equipment** to enable carers to take observations and utilise their new clinical skills.
2. **Provide virtual support for staff working from home** to minimise the risk of them feeling isolated or teams becoming disjointed.
3. **Establish ways to keep communication lines between teams open** so that knowledge is shared, since this is impeded slightly from working apart. Shared understanding of job roles when co-located is much easier as information naturally is picked up between team members sitting nearby.
4. **Continue the support in place for staff who are stressed or anxious**, but also for staff who are exhausted and working longer hours.

Appendix I: Overview of Key Learning in Categorised Themes

Pandemic Response

What Have the Key Changes Been?

1. **Relocation and reconfiguration of some services** have facilitated designated positive and negative areas to minimise the risk of infection. In some cases, such as non-urgent outpatient appointments, services were suspended to reduce risk to staff and patients.
2. **New ways of pre-collecting patient data prior to booking**, such as the Community Nursing Referral Form in Hull, anticipates the risk of patients presenting with COVID-19 symptoms prior to contact with staff.
3. In Patient Transport Services (PTS), **only essential journeys are being undertaken**, and bookings now only directly from receiving hospitals or outpatient providers, not from patients or primary care professionals.
4. A **Clinical Pathway Change Tracker** is in place to provide oversight of any changes to clinical pathways in response to COVID-19.
5. Rapid **distribution of PPE** across the region. Mutual aid and the sharing of and arranging the distribution of PPE.

What Were the Reasons for Change?

1. To **free-up hospital resources for urgent patients**, including operating theatres, anaesthetics, and inpatient beds.
2. To **reduce footfall in hospital** for infection control and social distancing purposes.
3. The limit of some services was necessary to help **facilitate rapid discharge of patients.**
4. Rapid dissemination of information and knowledge within and across the region was necessary for staff to **respond efficiently and with best practice**.

What Were the Keys to Successful Implementation?

1. The availability of **IT equipment and software**, such as Microsoft Teams, Fit Notes etc. was deemed to be essential in allowing the changes to take place.
2. Respondents felt that a **willingness to change and adapt** from staff was a necessary prerequisite for the greater demands asked of staff, including rota or role changes, extended hours, and the requirement to relocate temporarily.

What Have Been the Benefits of the Changes?

1. Geographical barriers have been removed with the introduction of virtual meetings to replace face to face meetings suggesting that collaborative working has **improved working relationships.**
2. The provision of a staff support line by telephone has meant that **staff have felt supported and have had access to essential, timely well-being support during the stressful times.**
3. Respondents felt that combined efforts to reduce footfall in hospitals along with anticipatory data collections have **increased patient and staff safety.**
4. The experience of working in a highly changeable environment necessitating redeployment and / or restricting of roles has created a **more resilient workforce.**
5. The working environment caused by COVID-19 **reduced barriers to the development of service and allowed rapid change** to take place.

What are Some Considerations in This Area Going Forward?

1. Find a **balance between face to face and virtual meetings** moving forward to accommodate the preferences of those who find virtual meetings more stressful.
2. The **longer-term provision of IT** to team members and within teams needs to be considered from a financial perspective.

Other

What Have the Key Changes Been?

1. PCNs across East Riding have **increased the rate of development towards maturity**, including submission of daily SITREPs to CCGs, contingency plans for COVID-19, agreeing bank holiday working arrangements, and sharing responsibility for each other's patients through the use of a centralised contact line.
2. There have been **changes to delivery of service**, for example, the primary safeguarding leads have established virtual meetings including attendance from GP surgeries, which was previously difficult because of the geography.
3. **Increased use of the voluntary sector**, for example, the British Red Cross provided a commissioned service to support in the discharge process by ensuring patients' basic needs are met and that follow-up support is available over the first few days after discharge.
4. **Increased Community Rehabilitation Bed Capacity** and increased medical support, including two junior doctors for bedded units and three frailty ANPs.
5. **Increase in palliative support**, including the involvement in pebble knitted heart work for when loved ones were unable to visit.

What Were the Reasons for Change?

1. The **working climate created by COVID-19** required a change in the delivery of patient care, including the requirement for a joined-up approach to maximise resource and efficiency.
2. **Staffing and resource challenges** necessitated further support from voluntary sectors, especially with early discharge.
3. Support to care homes was necessary due to the need to **minimise visitors** whilst continuing to meet patient need.
4. Changes to service delivery required **careful communication strategies to reassure patients and relatives.**

What Have Been the Benefits of the Changes?

1. The use of virtual meetings meant they were **more accessible**, making collaboration easier. This supported the **improved networking between colleagues** across the region.
2. The rapid changes within care homes has ensured **continuity of service provision within the care sector.** It is felt that there's been **improved resident experience** as a result.
3. Better planning around patient flow has **received positive feedback from patients, reduced delays in patient transfers and reduced time to receive clinical care.**
4. With the focus on community provision, there have been **fewer hospital admissions.**

What are Some Considerations in This Area Going Forward?

1. **Additional funding** will be required for current initiatives to continue, for example the British Red Cross support in discharge and community care.
2. There is a desire for some of the working groups **to continue sharing and collaborating post-COVID-19** to identify more opportunities for shared working.
3. **Evidence needs to be gathered** to establish whether changes to contingency planning have been most effective.
4. IT equipment needs to be **continually maintained and upgraded** to meet the needs in the long-term.

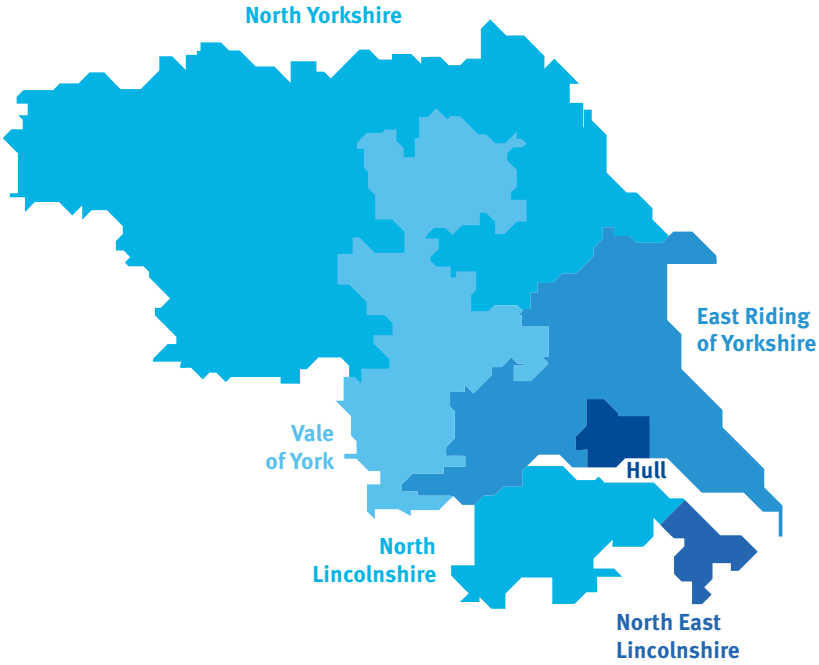
Appendix II: Case Studies

- **Primary Care Total Triage at Haxby Group**
- **24/7 COVID-19 Mental Health Support in North East Lincolnshire**
- **Dental Pre-Appointment Communications in Hull**
- **Video Conferencing and Consultation in Care Homes**
- **Jean Bishop Integrated Care Centre; Community Frailty Support Team- Hull and East Riding**
- **Rapid Discharge Process- York and North Yorkshire Control Room**
- **Delivery of Pulmonary Rehabilitation Services across Humber, Coast and Vale**
    1. Pulmonary Rehabilitation by York Teaching Hospitals and Humber Teaching Hospital
    2. Care Plus Group delivery of Pulmonary Rehabilitation using Zoom
    3. Virtual Reality Pulmonary Rehabilitation Pilot in North Lincolnshire
- **The 'Ask a Midwife' Service**
- **Virtual Parent Classes**

Primary Care Total Triage at Haxby Group

Humber, Coast and Vale Health and Care Partnership

Dedicated to improving the overall health and wellbeing of people living in Humber, Coast and Vale



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.

"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

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.

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)

Humber, Coast and Vale Health and Care Partnership

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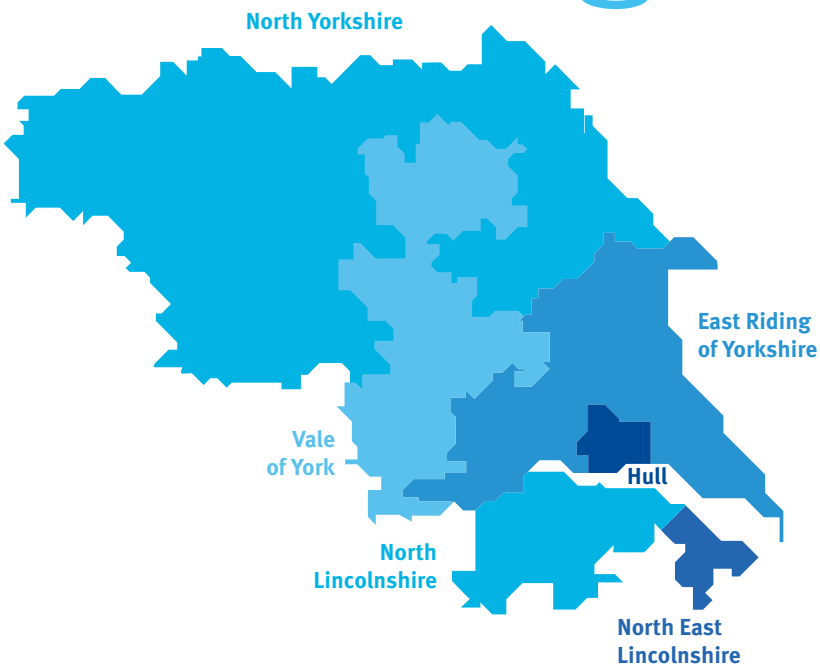

NAViGO have been successfully operating a 24-hour Single Point of Access (SPA) telephone line for over 11 years, providing mental health support to people with higher level, complex issues above the age of 18. When COVID-19 hit, the service was further enhanced, expanding to cover all ages and offering 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 1-2-1 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 2+ 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.

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

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 NEL 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

Dental Pre-Appointment Communications in Hull

Humber, Coast and Vale Health and Care Partnership

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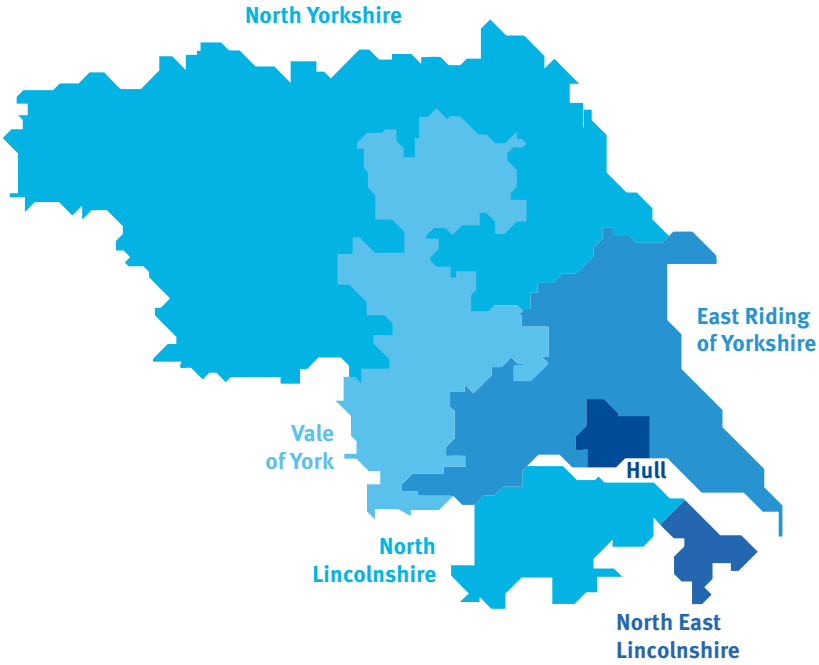

COVID-19 caused dental services in the UK to be suspended apart from emergencies. The paediatric service at City Health Care Partnership (CHCP) was commissioned to see specialist referrals and referrals of vulnerable young patients, most of whom they had never seen before. This meant managing the anxiety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

“I love it!”

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

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 Steps

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.

Interviewee: Elizabeth O’Sullivan, Consultant in Paediatric Dentistry

Video Conferencing and Consultation in Care Homes

Humber, Coast and Vale Health and Care Partnership

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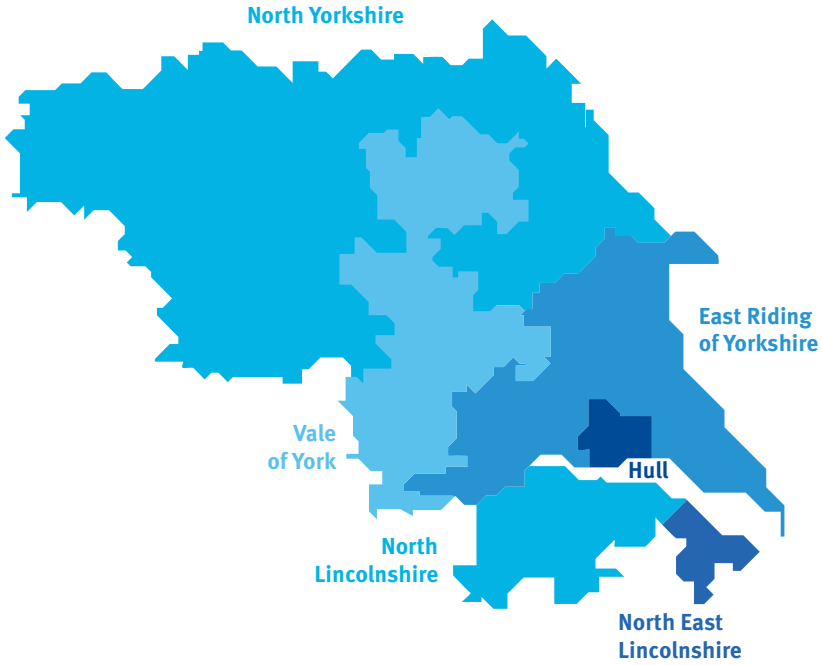

Care Home support became a national priority during COVID-19 response. The ambition of the work was to improve engagement and support with care homes whilst reducing the numbers of people entering and exiting care homes to reduce the risk to residents.

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.

"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

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 EPACS (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 on relation to some larger care providers with their own IT systems and it will be imperative 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 Points

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

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

Interviewee: Bruce Bradshaw, North East Lincolnshire CCG

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

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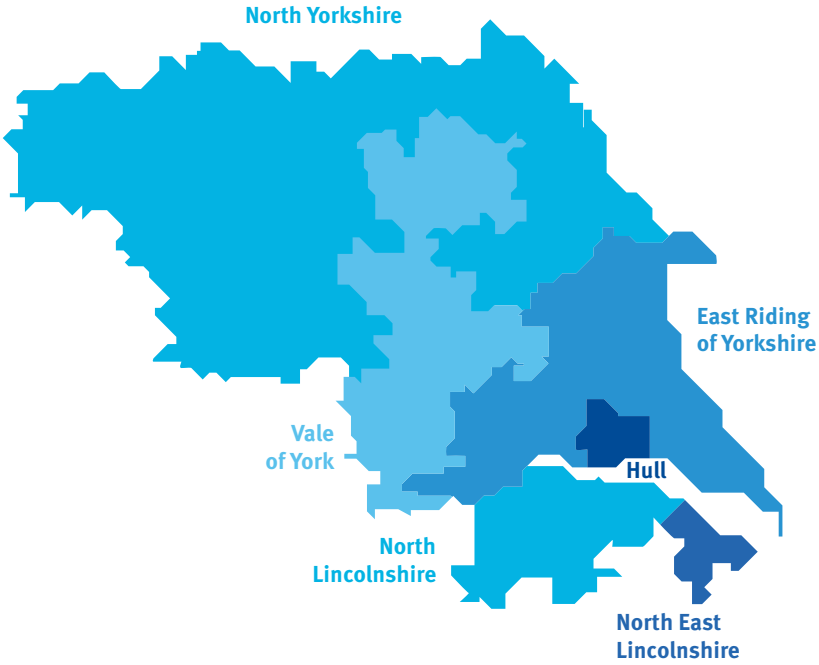

In response to the COVID-19 pandemic, it was predicted that high infection levels and mortality rates would overwhelm the healthcare service. A system wide approach was needed to ensure the right care was offered in the right place at the right time for frail residents living in their own homes and care 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 3 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 felt 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.

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

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 & 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 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. This 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.

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

Rapid Discharge Process - York / North Yorkshire Control Room

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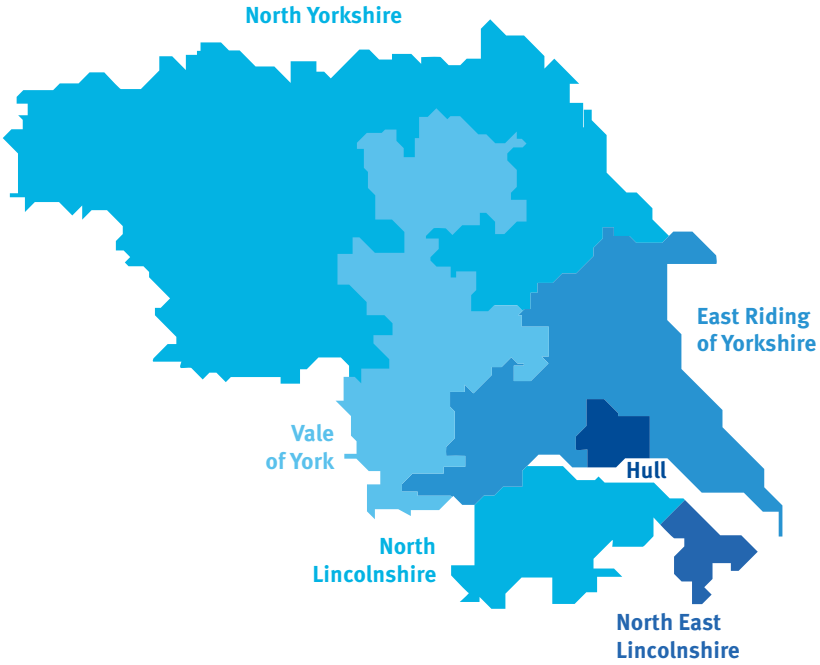


Pre-COVID-19 a significant proportion of the discharge process was spent within acute hospital settings completing assessments and evaluating the continuing needs of patients. In addition to this, an increased choice of care homes for self-funding patients can result in additional delays and constraints.

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.

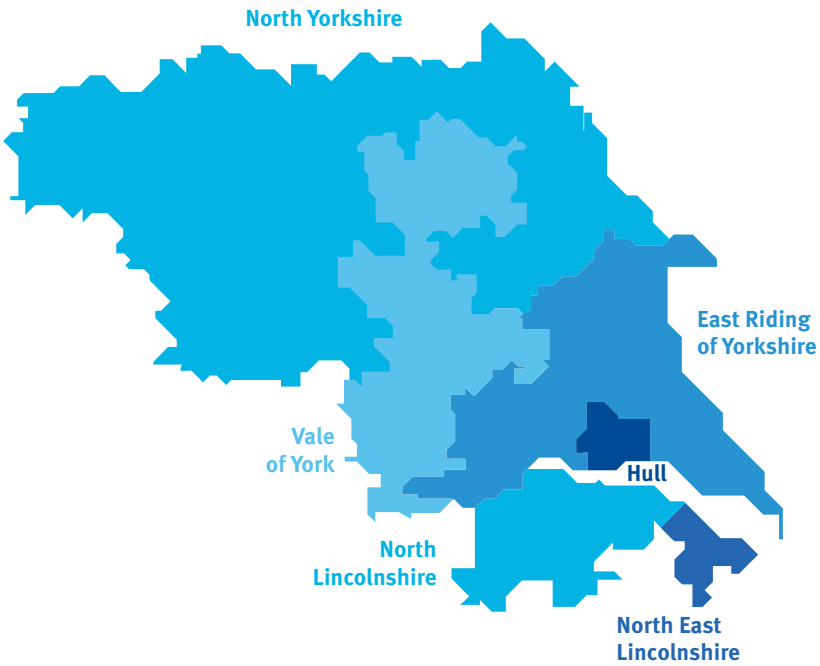
Key Learning Points

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.

Delivery of Pulmonary Rehabilitation Services across Humber, Coast and Vale

Humber, Coast and Vale Health and Care Partnership

Dedicated to improving the overall health and wellbeing of people living in 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:

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 10 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 1-to-1 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 cocreation 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 1-to-1 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 heart rate 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.

Testimonials

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.

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 by 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 Points

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 promotions campaign. A clear comms strategy surrounding the pilot will mean higher levels of participation from GPs.

Interviewee: Chloe Nicholson, North Lincolnshire CCG

The 'Ask a Midwife' Service

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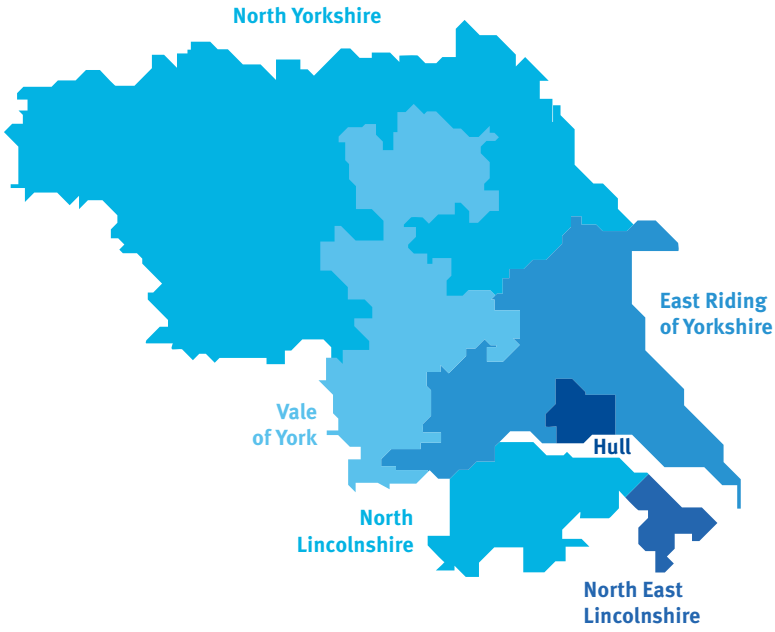


The Local Maternity System (LMS) in Humber, Coast and Vale have not had the option to pause or reassign their workload during the pandemic – whilst concern about COVID-19 was at its height, the babies kept coming!

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.

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

Anonymous Parent

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 Local Maternity System (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.

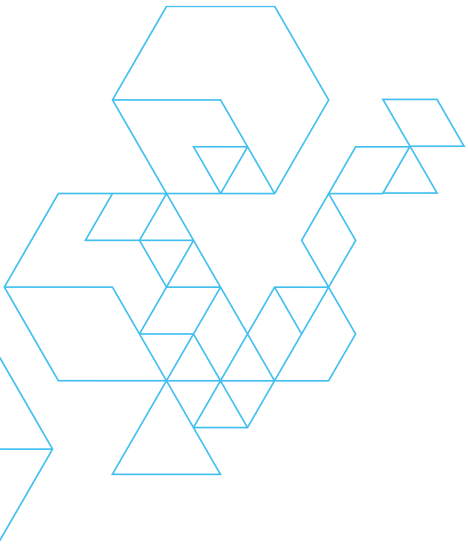
Testimonials

"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 every question I've asked"

Anonymous Parent



"Thank you so much, nice to hear off a professional thank you"

Anonymous Parent

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.

Interviewee: Sallie Ward, LMS Lead Midwife

Virtual Parent Classes

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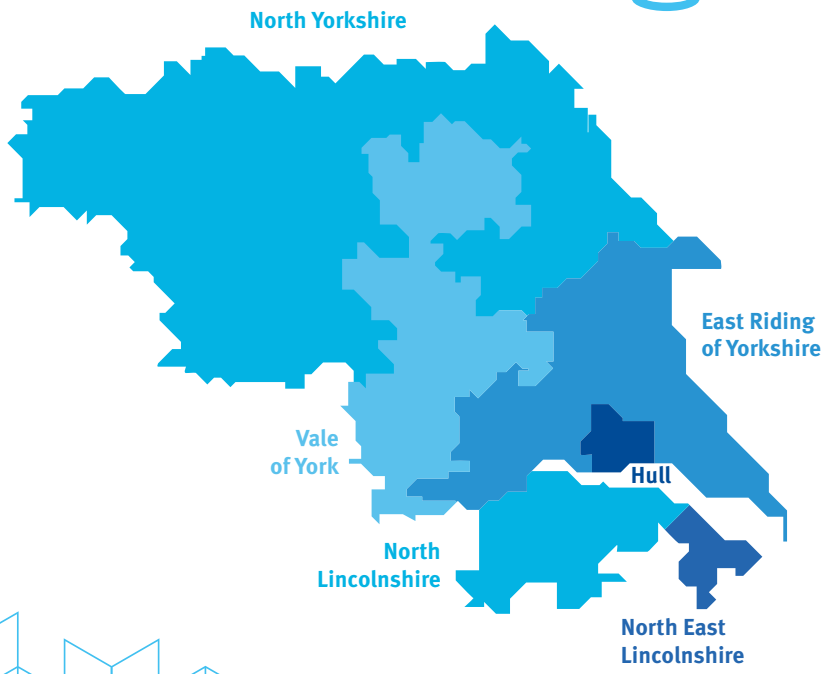

Due to COVID-19 all classes for expectant parents were cancelled to reduce face to face interactions and transmission risks.

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 3 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 6 couples.

1-to-1 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.

Approach / Methodology continued

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 4x1hour 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 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 delivery of classes.

Appendix III: Deeper Rapid Insight of Key Themes

- **Respiratory**
- **Maternity**
- **Outpatients**

Respiratory

COPD and Asthma affect approximately 2.2% and 6.5% of the population in Humber, Coast and Vale and before the pandemic around 11.3% of unplanned admissions in the region were due to COPD. The symptoms of the COVID-19 virus initially impact the lungs which meant it was important to shield these already vulnerable patients to reduce their risk of infection whilst maintaining as many services as possible to keep them safe and manage their condition at home.

Methodology

The AHSN engaged with already established groups such as the HCV Respiratory Steering Group and North Yorkshire and York Respiratory Steering Group to gain some general insights into how respiratory services have been affected by COVID-19. As well as group discussions, the AHSN conducted individual interviews with people who are involved in respiratory service delivery across the region. The key findings from these conversations are highlighted below.

Using Technology

There is a variation across the HCV footprint on accessibility to technology. Of those patients who have respiratory needs, as many as 80% of that population do not have access to the internet. This has a significant impact on how well a digital intervention can be implemented in the system and considerations taken to ensure the health inequalities gap doesn't widen.

Some face to face consultations are still taking place, especially for those patients who need urgent reviews and treatment. The majority of patient interactions have been via telephone consultation. NLAG, HUTH and YTHFT are preparing their respiratory services to utilise Attend Anywhere for virtual patient consultations.

There is a general recognition that services won't go back to being 100% face to face consultations and the ratio being considered is 70% virtual, 30% face to face appointments. This move is considered positive for both patients and staff as preventing unnecessary visits to hospital reduces the infection risk for these vulnerable patients and by saving staff time, it enables clinical teams to see those who need it most.

The MyCOPD app has been given to patients in the North East Lincolnshire, Scarborough and North Yorkshire areas, and is planned for use in the Vale of York, Hull and East Riding. Some aspects of the app, such as inhaler technique and medication support, are felt to be beneficial to patients however the pulmonary rehabilitation section is less well received due to the inability to adapt the exercises for the patients. Though there have been a lot of patient registrations in this app, it is not believed to have been regularly used, and some teams are considering evaluating both its use and patient attitudes to the app. North Lincolnshire are not using the MyCOPD app, when a patient needs support with inhaler technique or medication support, they recommend the RightBreathe App and Asthma UK videos on YouTube. Hull have not increased the registration of patients onto the MyCOPD app and only provide patients with the app for self-management once they have completed their three month telehealth COPD course (an education and support programme for COPD to monitor symptoms and understand baseline health data, such as oxygen saturation for future management).

North East Lincolnshire CCG have bought tablets for patients to use in sessions such as pulmonary rehabilitation, and North Yorkshire County Council have submitted a funding bid for tablets / iPads for patients to use during virtual appointments. They will be running a project to support people and increase their confidence in using digital technology. Some patients have bought their own kit such as blood pressure monitors and pulse oximeters to enable self-care and self-monitoring. Whilst this is seen as a positive step, there are concerns around training and the quality of the technology bought by patients. This has already led to incidents where a patient's self-reported oxygen saturation levels are low, and when evaluated in hospital (usually involving an overnight stay) their saturation levels have been fine. The discrepancy has been due to the inaccuracy of the kit at home.

The Cystic Fibrosis team at York have provided some kit for their patients to enable self-monitoring at home and York and North East Lincolnshire have some pulse oximeters for use in the community on those patients who can't purchase their own, with training available via Vimeo. Pulse oximeters (and training around use) have been provided to some care homes in the region to support the staff to monitor their residents on a weekly basis with their GPs.

In HUTH, their MDT to discuss the management of their COPD patients have resumed by utilising MS Teams. The team believe this format works well as it can be accessed from multiple places and reduces staff time loss due to travel and have identified this as a good format to maintain moving forward.

Appendix III: Deeper Rapid Insight of Key Themes

Diagnostics

Respiratory diagnostics such as lung function tests and spirometry are aerosol generating procedures. During COVID-19, these tests have been widely stopped to reduce the infection risk and are only available to those with immediate clinical need e.g. for lung cancer assessment prior to surgery. Work is still taking place to understand how diagnostics can be delivered safely within hospitals. The number of patients seen per day will be significantly reduced as there needs to be at least 45 minutes between patients for air change to take place and the room to be decontaminated. A large amount of PPE is required due to the aerosol generating nature of the tests.

As diagnostic tests are not taking place in hospitals, the clinical teams are contacting GPs for the latest spirometry values and using these during patient assessments. Lack of interoperability between primary and secondary care systems makes this process more challenging and time consuming.

The Respiratory Steering Group are looking at how community diagnostic hubs can be delivered with national guidance expected in the next couple of weeks. Considerations to be given include the location of the hubs (and rurality of some of the geography in HCV), the PPE requirements, the need to have sufficient air change between patients and having the facilities to do this.

Partnership Working

Though there were already pockets of work with good partnership working, the urgency of COVID-19 has led to a greater need to break down barriers and collaborate further.

In Hull, the acute respiratory team have built on their existing relationship with the Integrated Care Centre (ICC) to develop an MDT process and referral process to the ICC for patients being discharged following recovery from COVID-19, to enable the right care package for these patients in the community. In the first cohort, 260 patients were assessed, and the team are working through the second cohort of 170 patients.

The Respiratory Steering Group has enabled joint working to take place. Where one place has developed a solution to address a specific issue, that solution has been shared across the region to enable faster development and resolution of problems. There is a strong sense of acceptance that everyone is experiencing the same challenges and should be sharing what works.

Challenges

Many staff members have been redeployed into ward settings to support the COVID-19 response. This has affected how much work can be done to support patients through this time and in most cases, the majority of work has stopped. In York, a shielding doctor was able to conduct telephone consultations, and in Harrogate, all nurse led clinics have continued using telephone or video consultation.

For hospitals to maintain 'hot' and 'cold' areas, they have had to spread facilities into other settings, such as outpatients to accommodate this need. This creates a challenge for facilities within the hospital where there is less space to deliver outpatient clinics. There are recovery plans in place and the transition to open more outpatient clinics is being operationally managed.

Pulmonary Rehabilitation is the main rehabilitation support for patients with COPD, which involves face to face classes. Due to COVID-19, these classes have stopped, and services are reviewing how these can be delivered virtually or remotely for patients. It is anticipated the demand for pulmonary rehabilitation from the current cohort of COPD patients will increase due to inactivity during lockdown. This increase in demand will challenge the capacity of pulmonary rehabilitation services. More information around some of the challenges surrounding delivery of pulmonary rehabilitation and the variety of service models provided across the region can be viewed in the Delivery of Pulmonary Rehabilitation case study in this report.

Looking Forward

There is a desire from across the footprint to continue sharing what has worked, and to work together to address common issues. There will be times when demographics have an impact on what intervention can be implemented but the already established HCV Respiratory Steering Group and the soon to be established Clinical Network (due September 2020) will support the spread and adoption of work to benefit the whole of Humber, Coast and Vale.

There is a general expectation that there will be an increase in collateral respiratory deaths in the post-COVID-19 period. This is due to patient behaviour change in delaying contact with primary care when they have symptoms as well as primary care behaviour change around referrals to secondary care, especially with regard to respiratory conditions during COVID-19.

Redeployment of staff has led to some backlogs of patient reviews. Utilising technology will enable these reviews to take place faster but the patient's ability and access to technology must be taken into consideration.

It is expected that IAPT support will be needed for those patients who have been in the ICU due to COVID-19 and need rehabilitation and support during recovery, but also for those patients with long term conditions who have had to shield during the pandemic. A pilot is being established with TEWV on this.

Summary and Conclusions

Positive Insights - What has Worked Well

- **The Respiratory Steering Groups** have enabled partnership working and sharing of solutions to joint problems.
- Staff and patients have been receptive to **changing practices and using technology**.
- Patients have started using kit such as pulse oximeters to **manage their conditions at home**- this comes with other challenges, but the attitude change is seen as positive.

Challenges

- COVID-19 response has **affected availability of staff and facilities** to continue service delivery.
- **Pulmonary rehabilitation** before the pandemic was a face to face group programme and delivery virtually is a challenge.
- Respiratory diagnostics are aerosol producing and are only available for urgent cases currently. **Restarting routine diagnostics will be a challenge**.

Building on our Learning - Our Recommendations to Take Forward

- Both **patient and staff access to technology** needs to be considered before implementing technology and ensure the health inequalities gap does not widen.
- **Build on existing relationships** and utilise the HCV Respiratory Steering Group to share problems and solutions across the geography.

Appendix III: Deeper Rapid Insight of Key Themes

Maternity

The level of activity in maternity services remained constant throughout the pandemic whilst the actual services have changed to meet national guidance. Maternity Units across Humber, Coast and Vale have managed their daily demand for services whilst reducing face to face interactions for infection control purposes.

Methodology

The AHSN facilitated a discussion with the Local Maternity System (LMS), Maternity leads, and local Maternity Voices Partnerships to understand how COVID-19 has affected maternity services, how the system has adapted and what the learnings are from this. The key themes are highlighted below.

Staff

The regularly changing information around aspects of service delivery, such as PPE and social distancing, was challenging and increased staff anxiety. Trusts have done a lot to support their staff such as providing food, ceasing parking charges, sending out information to staff frequently and promoting the availability of HR and occupational health teams and resources - this was acknowledged as positive actions for staff and their wellbeing.

The strong leadership in the three Trusts and the support of the LMS, along with regular and frequent contacts to share problems and solutions has been beneficial for teamworking and camaraderie.

Shielding staff have been able to provide some services such as 'Ask a Midwife' which has been positive for their wellbeing as they continue to support women in the region who benefit from this service. This has allowed colleagues in clinical areas to have more time to care for women and their families.

Providing paid placements to students gave them a sense of belonging within the maternity units, which resulted in them taking real interest in what they were doing and owning the work they were involved in.

There were over 120 pregnant members of staff working in Hull University Teaching Hospitals alone during COVID-19. The LMS set up a WhatsApp group for those staff to support their wellbeing. The group has been very well received and is in regular use, with the LMS continuing to receive requests to add new staff members into the group.

Delivery of Maternity Services

Maternity services have the same number of pregnant women to see compared to pre-COVID-19, however some departments such as the Ultrasound Department have been running fewer clinics than they were previously supporting and have also had to limit the number of people coming in to each appointment which has had knock-on effects for maternity services.

Postnatal appointments were reviewed and where appropriate clinically, audio or video calls were used to replace some face to face interactions. The transfer processes between midwives and health visitors were strengthened to reduce unnecessary duplication of visits. This has been challenging but staff and women have worked together to ensure everyone feels as supported and safe as possible.

Maternity units have done their best to manage the number of people coming onto wards to protect women, families and staff from the risk of COVID-19. For example, in all units, partners were asked to wait until it was certain that the mum was in active labour before joining them during labour and birth. Whilst this was sometimes difficult for midwives to communicate, families were very supportive of this approach when they understood why.

The pandemic has enabled the maternity teams to implement innovative practice, for example remote monitoring plans for diabetes and blood pressure were brought in as planned but sooner than expected. The availability of technology such as laptops to community midwives as part of the COVID-19 funding has supported the delivery of innovative practices, although there is still more work to do on the integration of technologies.

Some parts of the previous service had to be stopped on national advice; for example, the recently established process of checking Carbon Monoxide readings for each woman at each check-up had to cease. This means that women who smoke during pregnancy may not have that visual incentive and reminder to encourage them to stop smoking. We know that smoking in pregnancy is a real risk factor for stillbirth and so this change may have significant impact further down the line.

Communication

In each of the acute Trusts, ultrasound and maternity teams sit in different care groups or departments. The ultrasound teams had to implement different rules to adhere to social distancing and provide a safe working environment for their staff depending on the size of the waiting area and clinic spaces they use. Maternity and ultrasound teams have worked together to explain why in some cases partners have not been able to attend scans, recognizing how difficult this has been for families.

The maternity teams found the short notice of guidance released to them from national bodies difficult to manage at some points. Where women and families contacted them about local queries, staff had to manage the conversations confidently and effectively to reassure women that work was being done to keep pace. The three acute Trusts working with the LMS coordinated consistent messages wherever possible to prevent confusion for parents.

Weekly LMS, Heads of Midwifery and Clinical Network meetings were viewed as positive and proactive. Information was freely shared in these meetings as everyone was working on the same things and facing the same challenges. The chairs of the Maternity Voices Partnerships have been involved in these meetings to provide a representative voice for the women and families being served by the maternity departments.

The 'Ask a Midwife' service; direct messaging via Facebook for women and midwives to communicate at set times each day, has helped give women access to the Trusts, and answer questions and queries about their local maternity services. This has been positively received by women and their families. Trusts have also been able to pass back important information.

On the postnatal wards, probably because there are fewer visitors the midwives have noticed women talking to each other more instead of drawing curtains around themselves. Anecdotally, the more relaxed environment has seen an increase in breastfeeding and women feel more supported and prepared for their next steps at home when they leave the ward.

Looking to the Future

It is unlikely that maternity services will run in the same way they did before COVID-19. Maternity Services and the LMS are working to anticipate challenges when starting to restore some of the services so that the benefits seen so far can be retained, but areas that have been missed by women and families can also be restored.

The 16-week appointment is being considered as a virtual consultation because in the vast majority of cases the blood test results discussed are normal, and women are happy to have an audio or video chat rather than visit hospitals. On the other hand, breastfeeding support has been trialled virtually during this period and was not as successful. It is the desire of the teams supporting women with infant feeding to get face-to-face sessions running again.

Summary and Conclusion

Positive Insights - What has Worked Well

- **Communications** have been viewed as a positive aspect in the way maternity services have changed and the 'Ask a Midwife' service has been integral in the way information and changes to service delivery have been rapidly communicated, as well as providing an outlet for women to ask questions and receive responses in a timely manner. Thousands of queries were answered between April and July and many families have let the LMS and Trusts know how grateful they are for this service.
- The pandemic has enabled the teams to **think about innovative ways to deliver services** and access to technology such as laptops and blood pressure monitors has been a key enabler.

Challenges

- Maternity units have had to reduce the number of face to face interactions and partners have sometimes not been allowed as much involvement as usual. This has led to **increased anxiety in both staff and families** - babies won't wait until the pandemic is over.
- The **release of national guidance** created challenges in communicating the impact of the guidance to women, whilst the organisations were still planning and actioning the changes.

Building on our Learning - Our Recommendations to Take Forward

- Continue to **utilise Partnership Programmes** such as the LMS across the system to support consistency of message, integrated working and solution-based thinking.
- **Include the Maternity Voices Partnerships** to enable coproduction of new services and support for change which includes the views of women and families.

Appendix III: Deeper Rapid Insight of Key Themes

Outpatients

Key Themes

- **Cultural and governance changes have allowed for accelerated transformation.** Incentive and motivation to adopt and adapt new procedures is very high, whilst governing procedures have been streamlined to allow implementation of changes to happen in days instead of months.
- One of the biggest landscapes for change has been **IT**. Again, enthusiasm from clinicians, patients and non-clinical staff has ensured a digital-first, if not digital-exclusive way of working.
- All partners are **keen to maintain the momentum of positive change** that has been realised in the response to COVID-19, whilst acknowledging the anticipated challenges that we may face in phase three.

Shared Areas of Change

1. Advice and Guidance

Positive insights – What has worked well?

- All regions recognise that, whilst there was an **emphasis on advice and guidance** pre-COVID-19, there is now an increased push for this across the board as a key preventative measure. North Yorkshire and York report a decreased demand between the months March-May, but in the context of decreased outpatient appointments.

2. I.T.

Positive insights – What has worked well?

- The **deployment of connected devices across the ICS** has been comprehensive and essential in providing a consistent service. The network of devices available has worked towards a truly mobile workface, concentrating on moving the dependency of the service away from a physical building. This means that clinicians and non-clinical staff alike will be able to pick-up and move to locations flexibly with minimal disruption to service.
- olutions such as Microsoft Teams has meant that the majority of staff have the **capacity to work remotely**. Hull and East Riding report cases where the productivity of secretaries doubled once working remotely, showing the potential efficiency saving costs associated with this new way of working.
- The **adoption of new digital clinical tools** across the region include but aren't limited to; changes in the booking system such as GPConnect, and digital signatures such as Fit Notes. Hull and East Riding are looking to remove free text from patient notes in consultant correspondence as a way of further streamlining the system in place, whilst Lincs are working towards digital dictation in order to be able to trigger the patient pathway.
- The rapid **deployment of connected tablets within care homes** across the entire ICS has provided a platform for the provision of primary care where it is needed. From this, it has been possible to build upon the service, for example, by enabling the use of Attend Anywhere in care homes across the region. This was highlighted in Hull and East Riding where patients are able to attend their appointment without leaving their bed.
- **Attend Anywhere** – The implementation of this service has been rapidly deployed. It has been well-liked and well-received by clinicians and patients in all areas of the region. In North Yorkshire and York, IT reported that on one day there were over 100 users of Attend Anywhere. They also note that Attend Anywhere has been particularly well received in medical specialities but that there is still work to do in surgical specialities.
- North and North East Lincs praised the 'off-the-shelf' national IT solutions, such as Attend Anywhere, which **circumnavigated lengthy procurement, trial and testing procedures.** Staff were able to access training modules and procedures right away, which meant implementation was rapid.
- Hull and East Riding highlight the **impact of video consultations in primary care settings on patient confidence**. "If a patient has encountered new technologies, such as video consultations, in the primary care setting – such as with their GP – they'll have less patient anxiety in secondary care when they encounter it again. The impact of this new technology at a primary level can't be underestimated."
- In Hull, it is reported that 60% of patients in virtual fracture clinics did not need to be seen after virtual review.

Considerations for the future

- All areas report concerns about **the long-term sustainability of the IT infrastructure** adopted during COVID-19. From a cost perspective, it is noted that the free license for Attend Anywhere ends in March 2021, at which point it may become unsustainable for the regions to fund themselves. Should the software change, North Lincs expressed concerns that the incentive to continue to use and adopt the new ways of working may lower from clinicians.
- Hull and East Riding have established an IT specialist in each admin team to help with the **technical challenges that have arisen from the adoption of new IT systems**. This highlights the ongoing challenge of maintaining support surrounding IT systems, where users (particularly patient end) may be inexperienced or have difficulties.

3. Hospital Sites

Positive insights – What has worked well?

- Across the board there has been a **flexible approach in response** to the challenges of COVID-19. These responses include the relocation of some services to 'cold sites' where private providers, for example the use of Nuffield hospitals in York, were used.

Considerations for the future

- Across the region, the different ages and types of buildings that make up the **hospital estates created unique challenges**. Older hospital buildings with narrower corridors make it difficult to manage the flow of patients. The entrance and exists are limited in older buildings, which created complex planning for departments. The small waiting rooms in some of the buildings were insufficient for social distancing regulations.

4. Staff Redeployment

Positive insights – What has worked well?

- All regions praised the staff in general for a flexible and positive response to **immense upheaval in the reshuffling and redeployment** of the workforce.
- One benefit to outpatient staff working on acute wards is a **general upskilling**, such as in Hull, outpatient nurses are now able to cannulate and healthcare assistants working alongside phlebotomists gained a greater appreciation for the importance of patient hydration when drawing blood.

Considerations for the future

- With staffing levels affected by those isolating or shielding, questions were raised about the **sustainability of staff redeployment** going into phase three. York, for example, reported some staff who have been working shifts and overtime on acute wards are exhausted, a feeling echoed across the region.
- The **psychological impact of working in an acute environment** was highlighted as a possible area of need in the future, such as in Hull, where outpatient nurses were seeing a dead body for the first time, or supporting families through the bereavement process. The stress and trauma of these experiences, compounded by long working hours, may create a need for emotional and wellbeing support for staff in the long-term.
- With **staff returning to work**, new challenges are presenting themselves such as allocating non-patient facing roles for those shielding when the numbers of such roles are limited.

Appendix III: Deeper Rapid Insight of Key Themes

5. Rapid Decision Making to Implement Change

Positive insights – What worked well?

- All regions report that the **decision-making process time was cut** from weeks or months, to days. This included decisions about patient care, where IT systems helped to streamline patient pathways and new triage systems ensured patient care was rapidly prioritised.
- In York and North Yorkshire, they implemented a CAS system so that triage happens before booking and patients are RAG rated as they enter the system. As part of the Core Patient Database (CPD), templates are being reconfigured for patient pathways.
- Because of the questionnaire feature within Attend Anywhere, **patient feedback is being actioned real-time by clinicians**. These relatively small tweaks and changes as a result of patient feedback increase confidence in patients for the service.
- Hull and East Riding have a new booking strategy, including a patient checklist prior to booking, for example, to establish whether they are shielding, to anticipate their care needs. Sign-off of changes have been taking place within 48 hours, rather than every month, thanks to streamlined governance arrangements.
- In North Lincs and Lincs, a Patient Contact Centre has been established, meaning that patients are centrally triaged rather than being triaged in the various admin teams. A primary and secondary care pathways group has been created to help support faster change, and it has been proven that this team has a place going forward.

Considerations for the future

- There is a keen enthusiasm across the board for **maintaining the momentum of decision-making** by retaining the governance arrangements that have allowed for this level of flexibility.

Summary of Questions Raised

1. Cost implications for national IT schemes:

- Could NHS England / the government provide financial support or funding?
- Could there be a regional licensing of software, such as Attend Anywhere, to make it more affordable?

2. Staff morale and wellbeing for the future:

- How can we support staff who are exhausted or stressed?
- How can we provide support for those who have experienced trauma in redeployment?
- Are there sufficient roles for staff returning to work who need non-patient-facing roles, for example those who are shielding?

3. Hospital sites:

- How can we 'COVID-proof' our older hospitals so that they will be suitable for use going forward?
- Can we identify long-term changes as a result of the relocation of services during COVID-19?

4. Maintaining streamlined bureaucracy:

Which groups established during COVID-19 would have a beneficial impact going forward in order facilitate decision making?

Next Steps

The Humber, Coast and Vale Outpatients Transformation Group continue to build on the learnings from our response to COVID-19 and at the time of publishing this report, the YH AHSN continue to work with the group and colleagues from across the system to enhance the learning shared above, utilising quantitative data and case study information to produce more detailed insights into specific outpatients activity. A follow up report on these initial insights will be provided to HCV Partnership.

Appendix IV: Primary Care Digital Learning

The full North East and Yorkshire report on the rapid insights into digital GP solutions during the COVID-19 pandemic can be viewed by clicking on the link or Scanning the QR Code.

bit.ly/digitalGPsolutionsNEY

Appendix V: Patient and Public Engagement Feedback

The full list of organisations that provided reports are listed below:

- **Deaf Community in York**
- **Dementia forward**
- **HCV Local Maternity System**
- **Healthwatch East Riding**
- **Healthwatch Kingston upon Hull**
- **Healthwatch North East Lincolnshire**
- **Healthwatch North Lincolnshire**
- **Healthwatch North Yorkshire**
- **Humber NHS Foundation Trust survey**
- **NAViGO**
- **Northern Lincolnshire and Goole NHS Foundation Trust**
- **Vale of York CCG Survey on the impact of COVID-19 on residents in the city of York, Selby, Hambleton, Pocklington and outlying areas.**
- **Vale of York CCG Case Studies: Carer of daughter with a Mental Health condition and Wheelchair service user, with a learning disability and registered blind**
- **York Carers Centre**
- **York Mind**

Key Findings

Communications

Positive Insights - What has Worked Well

Respondents praised when services proactively kept them informed about how they were operating, which greatly improved their experience of care. For example, 65% (of 20 respondents) of those surveyed by Healthwatch East Riding found it easy to find information about keeping safe during COVID-19.

What Could have been Done Differently

Respondents suggested that they would have had a more positive experience if they had received clearer and consistent information about social distancing, testing, face coverings, accessing healthcare services and COVID-19 in general. This would have reduced confusion relating to service availability and reduced anxieties about (re-) engaging in activities outside their home and keeping safe.

Building on our Learning - Our Recommendations to Take Forward

- Proactively keep service users informed about service availability and changes to care.
- Use clear, consistent and easy to understand langue in communications to patients and the public to reduce confusion.

Vulnerable and Protected Groups

Positive Insights - What has Worked Well

A review of organisations for older people in North East Lincolnshire found that GPs were thought to have provided a good service, particularly by getting in touch with people when they need it. People had no issues accessing community support, such as District Nurses, who provided support when requested.

What Could have been Done Differently

Concerns were raised for LGBT service users facing lockdown with an unsupportive family.

Some groups have experienced particular difficulties engaging in activities during social distancing. For example, people living with sensory loss and people who have not had access to a support worker. Unpaid carers – especially young carers – have been affected by difficulties accessing respite services and anxieties about the virus entering their household.

Difficulties keeping up to date with the latest information were faced by people living with dementia, autistic people and those who need information in an alternative language / format, such as Easy Read, BSL or if not fluent in English.

Building on our Learning - Our Recommendations to Take Forward

- Continue to offer support and activities for the vulnerable groups outlined here.
- Adapt communications for those with particular communications needs (such as information in languages other than English).

Appendix V: Patient and Public Engagement Feedback.

Access to Healthcare

Positive Insights - What has Worked Well

In general, service users had a positive experience of healthcare services during COVID-19. Positive comments included praise for healthcare staff, happiness with increased contact and the use of phone consultations. 56% (of 39 respondents) of Healthwatch North Lincolnshire respondents had a positive experience of GP Practices and 77% (of 20 respondents) of Healthwatch East Riding respondents had an excellent / good experience of healthcare services, during COVID-19.

Dementia Forward suggested that more collaborative working was seen a big positive, because it meant providing a joined-up response for patients, which has resulted in less duplication of referrals and less wasted time.

What Could have been Done Differently

When asked how their care could have been improved, respondents' suggestions included greater use of video consultations and remote monitoring, more communication about changed / cancelled appointments and easier sharing of patient information across organisations.

Concerns were raised as to how COVID-19 has caused difficulties with transport for patients needing to get to appointments. From Healthwatch North Yorkshire's experience, it seems that not all NHS staff know about the referral process for the NHS Volunteer Responder Scheme which involves a patient transport component.

Building on our Learning - Our Recommendations to Take Forward

- Continue collaborating / sharing across organisations to maintain patient care.
- Improve knowledge of the referral process for the NHS Volunteer Responder Scheme which involves a Patient Transport component.
- Provide more communication with patients about changes to appointments.

Mental Health

Positive Insights - What has Worked Well

64.2% (of 553 respondents) of NAViGO users reported that regular contact with care coordinator / therapist / worker helped them with their mental health during lockdown. 63.8% of NAViGO users also reported that they had received enough support during COVID-19.

What Could have been Done Differently

COVID-19 has caused delays for people on waiting lists for mental health services, which has caused further anxieties. Service users are worried that support groups will not open again and need reassurance that they will be there for them.

York Mind noted that people are being discharged when they need increased help. Problems include no access to Haven, the crisis service not answering the phone, and people not knowing how to access video services for mental health services.

Building on our Learning - Our Recommendations to Take Forward

- Proactively keep mental health service users informed over changes to services and reassure them if services / groups will continue post social distancing.
- Ensure that discharged patients have all the information and access to services that they will need.

Digital Change and Innovations

Positive Insights - What has Worked Well

Common benefits identified by service users for new digital ways of delivering healthcare services were the fast and efficient response from clinicians and the amount of follow-up after appointments. Patients said that they felt safer using digital tools, as they didn't need to go out and potentially catch COVID-19. 40% (of 553 respondents) of NAViGO users said that they had noticed benefits of new digital tools.

Respondents noted that they would not have been able to cope with their mental health during lockdown without the support they received via new digital tools, because it allowed them to realise that there was someone there for them when they needed them.

What Could have been Done Differently

Service users provided feedback that they would have preferred clinicians to be more willing to adapt their use of technology to a patient's needs (e.g. their condition or their lack of tech skills / access). Some patients found apps not user friendly and would have preferred to use more commonly used apps (e.g. Zoom or WhatsApp).

Particular problems were identified by those living in rural areas over poor quality connectivity. Healthwatch North Yorkshire heard about the impact of digital connectivity on people's mental health, with people who are digitally excluded experiencing loneliness and boredom – particularly older people.

Building on our Learning - Our Recommendations to Take Forward

- Allow patients the choice of having online or face to face (if safe) consultations depending on their preference.
- Adapt use of technology if the patient has a particular health need.
- Adapt the care administered depending on a patient's ability to use technology.

Patient Safety

Positive Insights - What has Worked Well

There were various concerns around the level of training and expertise that nursing home staff in care homes require to effectively take care of residents with COVID-19 symptoms, also noting that staff should have their temperatures monitored at the beginning of the day.
NLAG heard that patients seemed to accept the restrictions much more than their families who wanted to see them. They also conducted a risk assessment and senior nurse-led plan to allow end of life visiting early on in restrictions and extended this to vulnerable people soon after.

What Could have been Done Differently

There is concern around residents having access to the same level of medical care as people who live in their own homes, but also fears involving going to the hospital, attending regular GP or hospitals appointments for blood tests or macular injections at the eye clinic. Another issue was the effects on residents' health due to staying in their rooms; one care home responded by utilising the garden in line with social distancing rules.
Individuals who wanted to be part of the NHS Volunteer Responder Patient Transport scheme found it difficult to secure referrals due to PPE shortages.

Building on our Learning - Our Recommendations to Take Forward

- Training for nursing home staff on effectively and safely looking after vulnerable COVID-19 patients
- To allow patients in Care Homes the same level of medical care as those in their own homes.
- Adequate equipment for volunteers.

Appendix V: Patient and Public Engagement Feedback.

Social Care

Positive Insights - What has Worked Well

People still received domiciliary care and one service noted that there was a concerted effort to provide continuity for the first time with carers being assigned the same clients more effectively. Some families stopped carers / cleaners going to their older relative's homes from fear of infection.

What Could have been Done Differently

Some families moved in with older relatives and took responsibility for them, whilst another service found some had been left vulnerable with no replacement of support from families and were struggling with daily tasks.

Building on our Learning - Our Recommendations to Take Forward

- Ensure support is given to those vulnerable people with the focus on those whose families are unable to support them.

System Working

Positive Insights - What has Worked Well

Bluelight in North East Lincolnshire provided excellent support to AgeUK in helping them support people in the community and Focus dealt with referrals well.

What Could have been Done Differently

North East Lincolnshire (Older People) (NELOP) said providers did not hear from the Alzheimer's society and received many referrals regarding older people with dementia / memory issues to their own services.

One provider noted NAViGO was one of the first services to no longer visit people, but complex mental health issues were dealt with through the provider's staff going to the person's home and liaising over the phone with NAViGO. One provider felt the housing manager at the extra care scheme used COVID-19 as an excuse to slow down new joiners due to their wider complexity issues.

Building on our Learning - Our Recommendations to Take Forward

- Improve communication and ways of working between providers to ensure critical issues are addressed, monitored and improved on through working together.
- Ensure that single providers do not get bogged down as being the main point of contact, but to alert the issue to organisations who could be sharing the workload.

Wellbeing

Positive Insights - What has Worked Well

Families became more involved with their older relatives and wanted to keep them safe.

Initial shopping issues have now settled down and people are managing their needs via a combination of online shopping, local delivery services and essentials boxes as they adapt to a new norm.

There have been reports of positive experiences, such as where hospital staff helped the relative of a COVID-19 patient say goodbye, and their kindness and honesty gave ease during a very difficult experience. Healthwatch North Yorkshire also heard praise for local voluntary organisations and community groups, describing them as "exceptional. Really, really helpful''.

What Could have been Done Differently

Services reported that some older people were opting for herbal / folklore remedies which may cause long term issues in place of medication they could not access.

Some people talked about giving up their cars as they had not used them and had lost their confidence to go out. Time Bank Hull and East Riding told Healthwatch Kingston Upon Hull "Those living alone and isolated are missing physical contact as well as the routines of their 'old life'". Younger people also struggled with changed routines and lack of interaction with others. Single mothers are having a difficult time and often face financial worry. As there is no clear demographic, they stated support packages have to be on an individual basis.

York Careers Centre surveys showed stress and anxiety about COVID-19 caused an exacerbation of existing conditions in some such as epilepsy, mental health and also child to parent violence; "2 families caring for children with additional needs say incidence of violence towards them has increased since lockdown". The relevant teams / services are involved but the situation is tricky, and the Respect programme run by IDAS does not have much capacity and may not be relevant for all families, dependant on the age of the child.

York Mind (YM) shared impacts on physical wellbeing as clients reverted to less healthy coping mechanisms: eating and drinking more, negative script replaying that no-one cares about them. Reports of domestic abuse have also increased as well as breakup of relationships; "one client talked about the negative impact on her relationship with her husband (the more time they spent together, the more she realised they weren't in a happy relationship)".

YM also conveyed that social media has helped keep clients connected to friends, but the negative impact of this has been comparing themselves to others; a sense of 'others are coping why aren't I?' This sentiment was shared by a lady who felt guilty for allowing her children to use phones / tablets for long periods of time while she tried to work at home. The pressure of trying to work whilst home schooling is a common theme. A few clients reported difficulty in maintaining a positive mindset to being at home with constant news about COVID-19. This has caused difficulties in managing previous anxieties (OCD, PTSD, depression and experiencing inertia).

The Vale of York residents survey showed 41% (250 people) said COVID-19 had negatively affected their lives on a scale of 7 or 8 out of 10, and 12.6% (76 people) said it had impacted their lives 10/10.

When asked what worried them the most, 40% said COVID-19 had impacted on their mental health, 31% said the impact on their ability to be a carer, 60% said that not being able to see people was a worry for them.

Building on our Learning - Our Recommendations to Take Forward

- To ensure people in vulnerable situations are giving appropriate packages of support.
- To highlight the positive stories coming out of COVID-19 as the constant bad news can be a hindrance to those feeling isolated, living alone or who are dealing with the resurgence of pre-existing mental health conditions.
- To highlight and make widely available support measures for victims of domestic abuse.

Humber, Coast and Vale
Rapid Insights Report

Understanding our Response to COVID-19

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