December 2020

Rapid Insights Report

A summary report exploring the rapid response to the COVID-19 pandemic among health and care partners across South Yorkshire and Bassetlaw

South Yorkshire and Bassetlaw Integrated Care System

Yorkshire & Humber AHSN

Our vision is for everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.

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Foreword

As we have seen across the world, COVID-19 generated wide-scale disruption and significantly affected people's lives.

In the early stages of the first wave, partners from across the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) shared a common goal – to continue delivering safe and effective patient care whilst protecting the workforce as much as possible.

Their commitment and dedication to ensuring that people continued to have access to non-COVID related healthcare led to some remarkable transformations. This was a challenge given the heightened infection control measures, visitor restrictions and workplace challenges that the pandemic presented.

To ensure the learning was captured from these transformations, the Yorkshire & Humber Academic Health Science Network (AHSN) and the South Yorkshire and Bassetlaw ICS joined forces to gather information about the rapid changes that were taking place; then evaluated these insights.

This rapid insights report explores these changes in more detail and considers which of them could be incorporated into future services, and identifies those that require more work, testing or consultation. It also highlights behaviours and organisational culture change that accelerated the rapid transformations.

Our hope is that these reflections put us in a stronger position to take forward the SYB vision to support everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.

For more information on the programme, please contact the Yorkshire & Humber AHSN programme team: info@yhahsn.com

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1 Introduction

The challenges brought about by the response to the COVID-19 pandemic resulted in a need to rethink the delivery of some health and social care services in South Yorkshire and Bassetlaw. Partners responded quickly to some of the most complex challenges ever faced by our health and care system, and in doing so created a number of exciting innovations and opportunities.

Rapid transformation brought teams closer together; it ensured patients could still be seen by their clinicians, it enabled families to stay connected with loved ones, it allowed staff to continue their work remotely and it forged new and lasting relationships that improved patient care and treatment.

It is essential that we learn from the SYB response to the crisis and take the opportunity to capture insights that can positively shape the future delivery of health and care services across the region, locking in transformational changes and embedding them for the future.

To facilitate this, South Yorkshire and Bassetlaw Integrated Care System (South Yorkshire and Bassetlaw ICS), led by Lisa Kell (Director of Commissioning), undertook an extensive review and evaluation of changes that took place across Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield during the early stages of the pandemic.

At the same time, the ICS worked in partnership with the Yorkshire & Humber AHSN to deliver a rapid insights programme of work to generate essential learning and reflection on the system response to COVID-19. This work also forms part of a region-wide programme across North East and Yorkshire, led by the AHSN with the regional team.

The rapid insights work is the first part of a phased approach to understanding and learning from SYB's short-term response to the COVID-19 pandemic, whilst also actively planning for a medium to long-term approach.

By the end of November 2020, the next steps will be to identify a short list of innovations that will be selected for more detailed evaluation. We will then begin to explore the use of a Quality Improvement (QI) sustainability model for selected exemplar projects to better understand their longer-term viability for roll out across the system.

In terms of our national compliance frameworks, the work we have undertaken so far has been done in alignment with NHS England and NHS Improvement (NHSE/I), with the next national NHS planning round reset for Phases 3 and 4 being fed into the North East and Yorkshire region. This will directly support and influence the cross-pollination of learning across Yorkshire's regional health and care systems.

For more information on the programme, please contact the Yorkshire & Humber AHSN programme team: info@yhahsn.com

Approach and Methodology

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

- Recent service changes and improvements have been recorded and promoted
- New and improved ways of working are embedded
- Lessons are learnt, with changes and improvements assessed to recognise their short-term impact and future value (both intended and unintended).

To support the delivery of these objectives, a set of guiding principles was established to help support and enhance the information capture and evaluation stages. This helped to ensure that the approach taken was as inclusive and wide ranging as possible and that where it was available, the information provided was evidence based. We recognise that the undertaking of this piece of work continued in real time while responding to the ongoing COVID-19 outbreak. Therefore, we must acknowledge that we may not have captured everything in this initial review phase.

To provide a widescreen review of the scope and scale of the changes made, we have captured information from across the breadth of the SYB ICS.

This includes:

- All of the health and care sectors
- Clinical and non-clinical elements
- Organisations and places
- The digital agenda

Due to the operational and clinical pressures faced by colleagues across the system during this challenging time, a mixed-methods data collection approach was used to capture information.

Insights were gained using the following data collection methods:

- Surveys (templates and online form submissions)
- Semi-structured interviews
- Facilitated sessions
- Secondary research, including public and patient engagement feedback.

Research Limitations

The research aims were to capture a broad range of experiences within a limited time frame. As such, the results must be viewed in the context of the breadth of the partnership, and it is not intended to be a fully comprehensive review. Instead, it should be viewed as the initial phase to inform future research, with further additional reviews as the COVID-19 pandemic unfolds.

Summary of Key Findings

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This section of the report discusses the key themes and findings captured from the rapid insights programme across SYB ICS.

The key findings have been developed from collated data from 36 respondents, mostly those in leadership roles, in response to our rapid insights questionnaire. The analysis from these responses was then subsequently paired with learning outputs from two ICS-led workshops held in May 2020. These workshops were designed to specifically review the SYB response to COVID-19 and the resultant transformational changes made across our five places – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

The collated feedback data was then grouped into key themes using a thematic approach to highlight feedback within key areas around what 'worked well', challenges identified and considerations for the future. The specific key themes are as follows:

- **Remote Working:** (how we have) established remote working to keep staff and patients safe
- **Technology:** deployed technology resources to meet staff, patients and service needs
- **Partnership Working:** worked with our partners to provide consistent care across the region
- **Patient Safety:** responded to the crisis by prioritising patient safety within the ICS but also across the wider region
- **Behaviours:** seen a shift and change in behaviours and attitudes both locally and across the region
- **Leadership:** managers supporting their teams and colleagues
- **Enablers for Change:** the emergence of significant identifiable reasons that have directly contributed to change

Remote Working

How we have established remote working to keep staff and patients safe.

Positive Insights – What has Worked Well

The uptake of software such as Microsoft Teams, alongside the fast deployment of laptops and IT equipment, has allowed many staff (in health and care organisations) to work from home whenever appropriate. Virtual meetings have resulted in significantly less travel to and from workplaces. Beyond the positive environmental impact, this has led to reduced travel costs and improved workstation time. Remote working has also seen time savings from not needing to commute between regional and national locations for meetings.

On this subject, meeting structures such as daily check-ins and team meetings have enabled staff to continue feeling part of the 'group dynamic'. It has also been beneficial to staff who often 'hot-desked' or had no set workstation in the office. Some staff members reported that this old way of working did not help them feel like part of a team.

Workshop feedback suggests there has been a positive impact on mental wellbeing. This is likely due to breaks and downtime being shared in the company of household family members, flatmates and pets, or participating in recreational activities such as running, walking or cycling.

Lessons Learnt – Areas for Improvement or Further Exploration

We found that some respondents reported challenges in homeworking, often around creating clear boundaries between their home and work life. Other respondents often found managing interruptions and disengaging from distractions in the home of particular challenge (especially those members with children at home).

The performance of technology, including slow or old equipment or poor internet connectivity, was reported as an issue by some respondents. Similarly, our workshop feedback suggests there has been inconsistent access to hardware and equipment across the ICS. For example, some administrative staff had no access to Virtual Private Networks (VPNs) or use of a laptop for lengthy periods of time (weeks and months).

We heard that staff felt they needed or would have liked more support to manage their diaries since virtual meetings and calls were often scheduled back-to-back. This can prevent staff having sufficient time for breaks.

Building on Our Learning – Our Recommendations to Take Forward

- Technology support or guidance for staff would help our workforce manage and deliver more efficient virtual meetings.
- Opportunistic and casual work conversations are missed through remote working and so face-to-face working should not be completely replaced.
- Flexibility for remote working going forward will support a number of staff to manage their work-life balance, achieved through the increased flexibility and reduced travel time to workplace.
- Encouraging and enabling staff to adjust their work patterns will support their wider wellbeing needs. Taking regular breaks, adapting their working hours to fit around family life and scheduling 'non-working time', such as virtual coffee breaks, are some reported examples.
- Respondents expressed a desire for some specific advice and guidance to make the best of longer-term homeworking, as well as some support in setting up a suitable workstation (e.g. advice around desks/chairs).

Working from home has been a great help towards my wellbeing. Without the commute, I feel I can work longer without the worry of being stuck in traffic.

Staff member,
The Rotherham NHS Foundation Trust

Technology

How we have deployed technology resources to meet the service needs.

Positive Insights – What has Worked Well

The rapid deployment of laptops and equipment across the region allowed teams to work from home wherever appropriate. The use of other software, such as Attend Anywhere, WhatsApp and accuRx, allowed for remote video consultations. This ensured continuity of care with anecdotal feedback across the region suggesting that this was well-received by patients since it allowed for more flexibility in service and improved accessibility. The Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) reported a decline in Did Not Attend (DNA) rates from missed appointments as a result. Respondents also called for the development of the Electronic Patient Record (EPR), as well as electronic prescribing and e-signatures, to allow for paper-light working going forward.

The necessary provision of virtual staff training enabled the rapid upskilling of staff, which also received positive feedback. Staff reported online training as being flexible, engaging and an accessible alternative to in-person training.

Staff explored a range of technologies in a creative way to support patients who they weren't able to see face-to-face. For example, in Speech and Language Therapy, staff created YouTube videos of voice exercises with useful information around how communication and swallowing may be affected by certain conditions. This was an adaptive way of delivering care, and in doing so, supported therapy patients' progression in the short-term.

Lessons Learnt – Areas for Improvement or Further Exploration

Whilst feedback in this area was overwhelmingly positive, some respondents did express concern that several patients did not have access to the necessary technology to access digital healthcare. Furthermore, respondents reported some technical problems with the introduction of IT equipment in new settings, for example, in care homes or environments where the technology has not been used before.

Building on Our Learning – Our Recommendations to Take Forward

- Some respondents are considering how to provide digital access for those without technology. In RDaSH, for example, ideas are being discussed about loaning equipment to patients and setting-up digital clinics where individuals can access technology in a sanitised clinical environment.
- To embed virtual clinics post-COVID-19, consideration should be given to how this is going to be balanced with face-to-face appointments.
- Streamlining processes to ensure that the most appropriate technology is being used given the range of new hardware and software that has been introduced.
- Addressing concerns around the ongoing funding of software, such as Attend Anywhere, which has been widely used during the lockdown.

CASE STUDY: Virtual Visiting

Contact: Beccy Vallance, Clinical Lead, Quality and Improvement, Doncaster and Bassetlaw Teaching Hospitals

Problem: During the COVID-19 crisis, it was difficult for relatives to get into the hospital to see patients.

What changed?: Virtual visiting was introduced onto the wards via tablet devices and using a Starleaf Application. Standard work was written for staff on how to schedule a call. A video was also set up for relatives on how to make the call on the Trust webpage.

Impact: Very positive feedback from patients and relatives:

"Being able to communicate face-to-face with our loved one in a time of separation and isolation gave us hope and comfort. He wasn't alone and we could tell him we loved him and that was something we would not have been able to do without this facility. We were grateful that we got to see him and it gave us peace and closure."

"It was heart-warming to be able to see him. He has possibly become near end of life and thanks to you all we got to say what we needed to say. Pleased that all of the staff involved."

Partnership Working

How we've worked with our partners to provide consistent care across the region.

Positive Insights – What has Worked Well

The rapid response required during the initial outbreak is reported to have forged stronger relationships between individuals and across organisations. The abrupt changes and pressures as a result of COVID-19 required greater collaborative approaches between organisations across the region. The intensity of the experience, combined with the necessity to work cooperatively at pace with colleagues across partner organisations, is said to have enabled closer working relationships with partners, key connections and alliances.

As a result, the majority of respondents reported a closer working relationship and increased trust between partners.

Feedback also suggested that there were more efficient and clearer communication lines between partners. There was an increased number of meetings and ongoing conversations between teams to quickly relay information in real time. In workshop feedback, it was generally felt that collaborative working performed best where there were pre-existing relationships. Similarly, networks have been a powerful tool in making change happen at both scale and pace.

Resources shared across teams and staff were also said to support busy services. For example, the Yorkshire Ambulance Service NHS Trust (YAS) worked to identify capacity and human resource to assist other departments. This included providing administrative staff to support command structures and redeploying clinical staff into call centres and/or to support the frontline in rare circumstances. In The Rotherham NHS Foundation Trust, this led to new cross-system governance structures being established, including a gold command strategic group and a cross-system community operations group. These groups met three times a week during the peak of the pandemic outbreak, bringing together partners from across primary care, physical and mental health, public health, social care and commissioners. Smaller specialist teams, such as the Palliative Care Team in Rotherham, reported that there was noticeably more recognition within the Trust of their role and function now.

Lessons Learnt – Areas for Improvement or Further Exploration

Overall, the feedback from respondents about partnership working was positive. However, there were suggestions that the increased communications activity between teams could sometimes feel like 'information overload', especially at the beginning of the pandemic. Respondents did suggest that with the number of meetings now being scaled back, this would help to alleviate this sense of information excess.

The Yorkshire Ambulance Service NHS Trust (YAS) reported that, as an Ambulance Trust, some partners underestimated their role in underpinning a system-wide approach, and as a result, there was a challenge to gain sufficient access to data or be included in more detailed planning.

Building on Our Learning – Our Recommendations to Take Forward

- Enhanced partnership, and all the benefits joined-up working brings, to continue working in this way going forward. In RDaSH, a project is underway between commissioners and partners to better understand capacity and demand modelling; this is with a view to progress a re-balanced, wrap-around community care model providing enhanced community support.

- The ability to exchange and share data across partner organisations in a data-compliant, but ethical, way will further support joint-working and facilitate rapid delivery.
- Continued 'system-wide' approach to engagement should continue between and amongst partners, including the community sector and social care.
- Try to extend the networked model further in future with the general feeling that it has worked well.

Patient Safety

How the region has responded to the crisis in prioritising patient safety.

Positive Insights – What has Worked Well

To address the crisis, respondents stated that they have had permission to relax the traditional models of care by prioritising what matters most to patients and their families. There has been a focus on 'home first' care and rapid discharge back into the community. This was true in Rotherham with The Rotherham NHS Foundation Trust (TRFT) reporting that admissions to care homes dropped and 93% of patients were discharged back home.

Providing flexibility in the provision of care has been a priority, as seen through video and/or telephone consultations. Some respondents felt that their ability (and quality) of patient care delivered remotely had improved over the course of the pandemic. With improved telephone assessment and communication skills, areas such as the provision of medicine and e-prescriptions limited the patient risk of COVID-19 exposure whilst also providing a timely service. Drive-through phlebotomy services also limited patient risk to COVID-19 and received positive feedback from patients.

Lessons Learnt – Areas for Improvement or Further Exploration

In palliative care, it was sometimes felt that it was more difficult to meet patient needs using phone or video consultation methods. Elsewhere, it was felt that the process of risk assessing each patient prior to offering an appointment, either digital or face-to-face, was sometimes a time-consuming process.

Building on Our Learning – Our Recommendations to Take Forward

Generally it was felt that we may have a better understanding of vulnerable households and their wider health and care needs. The Barnsley Clinical Commissioning Group (Barnsley CCG) suggests that future planning can, and should, be informed by this understanding.

CASE STUDY: Remote Provision of Pregnancy Advisory Clinic

Contact: Rani Prajwala, Locum Consultant in Obstetrics and Gynaecology, The Rotherham NHS Foundation Trust

Problem: There was a need to continue to provide this service but with as little face-to-face contact as possible.

What changed?: The service began to conduct telephone consultations, alongside a one-stop clinic offering a full range of necessary healthcare services, including termination and contraception methods. Local anaesthetic procedures were also provided which otherwise would have needed general anaesthetic in theatres.

Impact: The service was well subscribed and DNA rates came down.

Behaviours

How behaviours and attitudes have changed across the region.

Positive Insights – What has Worked Well

We heard that there was generally a willingness to be flexible across the workforce with examples including changing rotas to meet demand and redeployment of staff (where necessary) into new teams. The overwhelming feedback in this area suggested staff have become more effective communicators. There was also a clear indication that staff had become more resilient and more aware (and receptive) to the challenges faced by partner organisations. This has allowed for a 'whole Trust' response to the crisis and enabled rapid changes to happen more quickly.

It is generally felt that there is an appetite for – rather than an aversion to – change. Lessening of governance and streamlining of decision-making pathways has helped to harness this receptivity to change. As a result, it allowed for transformations to be made more rapidly. In addition, the greater range of options for workplace communications through new technologies has given access to a wider support network of individuals and organisations.

Lessons Learnt – Areas for Improvement or Further Exploration

Despite the benefits of new communications technologies, some respondents still missed the office environment. Specific reference was made to casual face-to-face conversations in offices with colleagues to get quick answers or clarity on work questions. Instead, a number of staff respondents voiced that these tasks now need to be written-out in email, messenger apps or text. Furthermore, workshop feedback suggests there was some noted job insecurity amongst ICS staff on fixed-term contracts.

Building on Our Learning – Our Recommendations to Take Forward

- Enthusiasm was reported in workshop feedback to keep communication lines open. This would support staff wellbeing and feeling of connection with the wider ICS workforce. In particular, there is a desire to keep the weekly ICS meeting and the daily check-in with teams. These meetings are said to support morale, provide an opportunity to assess general wellbeing and workload pressures, and enable more free-flowing conversation.
- As we transition back to 'normal' working, we heard that respondents are keen to maintain change momentum and find a balance in workloads.

CASE STUDY: Enhanced Staff Wellbeing and Support

Contact: Sarah Bowman, Director of Recovery, RDaSH

Problem: Staff put under increased pressure due to unprecedented demands of COVID-19 response. Adapting working environments was considered important to maintain wellbeing in order to have a fully operative workforce.

What changed?: Enhanced provision for staff, including 'wobble rooms' and a psychological wellbeing model.

Impact: Staff from across the organisation have provided positive feedback, leading to the organisation exploring the option of this being an ongoing offering by utilising some charitable funds to support the costs within this financial year.

Leadership

How managers have supported teams during this time.

Positive Insights – What has Worked Well

Increased communication between leaders and team members was noted among a high number of respondents. Regular check-ins, beyond work matters to ask about staff wellbeing, were also considered a beneficial outcome of remote working. Workshop feedback suggests that leaders have supported flexible working and brought clarity to teams when things were uncertain, especially in the beginning. We heard that clinical leadership has been strong and collaborative, whilst ICS leadership has supported cross-system working. We heard that leaders have been more visible and accessible to the teams during this time. Furthermore, leaders have demonstrated increased trust in staff by delegating effectively.

Command and control also had a large influence on decision-making through its unilateral obligations for organisations across SYB.

Lessons Learnt – Areas for Improvement or Further Exploration

We heard some leaders advise that the daily calls for command and control purposes could be time-consuming. However, the frequency of these has now been reduced accordingly.

It was also suggested that there was sometimes a lack of clarity or expectation around new clinical leadership roles, which inadvertently made the transition into these new posts more challenging.

Building on Our Learning – Our Recommendations to Take Forward

- Ongoing leadership visibility – to the same level of proximity – is considered a highly desirable outcome; workshop feedback suggests that weekly Senior Leadership Team catch-ups are an important part of this.
- Continued use of Microsoft Teams to enable open and regular communication between Senior Leadership Team and other teams is considered essential. There is a strong desire for Microsoft Teams to be kept as part of default workplace communications within the health and care landscape going forward.
- The empathetic style of leadership has been valued with staff wanting this personal approach to continue.

Enablers for Change

A small number of significant factors are considered to be key enablers, which can be summarised as follows:

- **Funding** for new technology, software and equipment, and to support new pathways in place.
- **Technology** such as Microsoft Teams, as well as the infrastructure necessary to support the use of this, including, importantly, connectivity.
- **Agility of workforce** in a time when rapid change and decision-making have been necessary for continuation of service; a willingness to change working patterns, ways of working and place of work, either by working from home or by redeployment, are considered important attributes.
- **Collaborative attitude to working,** including a willingness to share data and information within a compliant and ethical framework, and to share resources, including staffing resources.
- **Relaxed bureaucracy and streamlined governance** allowed for a shared vision across the region and offered a strong sense of direction to drive forward the rapid change.


LIMES
sunpack

Patient Feedback 4

This section of the report discusses the findings from patient engagement activity, making a number of useful recommendations for enhancing the patient experience across SYB. It provides insights and consolidated learning outcomes from Yorkshire & Humber AHSN's engagement exercise, which involved teams and individuals from across SYB.

Conducted from early-June to mid-July 2020, this project is part of the wider Evaluation and Reset work of the Yorkshire & Humber AHSN, which brings together information collated from external reports, insights and findings produced by the organisations listed below:

- Cavendish Cancer Centre
- Citizens Advice Bureau
- City-wide Equality and Engagement Group (Sheffield)
- Community Networks
- Community Swabbing Service patient survey
- Deaf Advice Team
- Dementia Strategy Implementation Group
- Digital Inclusion Sub-planning Group
- Disability Sheffield
- Facebook Community Group: Darnall Wellbeing & Together Women
- Facebook Community Group: Voluntary Sector (Sheffield)
- Faithstar
- Firvale Community Hub
- Gold Command
- Healthwatch Barnsley
- Healthwatch Doncaster
- Healthwatch Nottinghamshire – Bassetlaw
- Healthwatch Rotherham
- Healthwatch Sheffield
- Healthy Holidays
- Macmillan Cancer
- Mental Health Partnership Network
- National Carers UK report
- NHS Sheffield CCG Community Insight survey
- Office of National Statistics – Deaths Involving COVID-19 by Local Area and Socioeconomic Deprivation
- PKW South Locality Network
- Public Health Information Network
- Public Health England – COVID-19: Review of Disparities in Risks and Outcomes report
- Refugee Council
- Rotherham Ethnic Minority Alliance
- SAYiT
- Sheffield Care Options
- Sheffield Carers Centre
- Sheffield CCG Complaints Team
- Sheffield City Council
- Sheffield Health and Social Care NHS Foundation Trust

- Sheffield International Venues and Links School Sport Partnership
- Shipshape
- South Locality meeting
- South Yorkshire Community Foundation
- STH Cancer Clinical Nurse Specialist and Cancer Support Worker teams
- SYB Suicide Steering Group
- Terminus Initiative
- Together Women
- Voluntary Action Sheffield
- Weston Park Cancer Support Centre.

The key findings from this section of the report have been separated into the following themes:

1. **Access to Healthcare:** changes we have seen in how our services are being used
2. **Care Homes:** the impact on patients and staff in care homes
3. **Communications:** the process by which we have shared key information and messages
4. **Digital Changes and Innovation:** embracing new technology and innovation to support rapid transformation
5. **Mental Health:** the impact on patients' mental health and SYB's mental health services
6. **Patient Safety:** the complications and adaptions to maintain patient safety and mitigate risk
7. **Vulnerable and Protected Groups:** the impact of COVID-19 on at-risk groups, especially those with protected characteristics based on the Equality Act 2010
8. **Wellbeing:** the experiences of patients who have experienced COVID-19 during their day-to-day lives.

Access to Healthcare

Positive Insights – What has Worked Well

Patients had the best experiences when their access to healthcare was least disrupted. For example, Healthwatch Sheffield received positive comments about cancer services from patients whose diagnosis, surgery and results have been handled quickly and within the expected timescales.

The Community Swabbing Service patient survey highlighted very good feedback, with 100% of respondents rating the service as good or very good, particularly with staff.

Lessons Learnt – Areas for Improvement or Further Exploration

It was difficult for those who are shielding, or otherwise to access their GP or pharmacy, to fix issues around delayed prescriptions or prescriptions being delivered with medication missing. There were reports that people's care packages were being reduced as the access to the community element was being taken out.

Patients highlighted concerns over delayed or rescheduled care for non-COVID-19 health issues. For example, in Healthwatch Sheffield's feedback about the continuity of cancer services, many patients had not yet started their treatments. Screening rates had also reduced during lockdown restrictions, particularly among vulnerable groups. Sheffield Care Options report waiting times for gender identity clinics have increased from 20 to 30 months.

The Asylum Seeker and Refugee Community reported that accessing healthcare services had been difficult, with challenges including the automated system at the start of a 111 call, lack of interpreters available and delays in registering with a regular dental practice.

Building on Our Learning – Our Recommendations to Take Forward

- Review how to maintain supply chains for prescriptions.
- Continue to keep patients up to date on changes to appointments, treatments and care packages.
- Ensure that access to services meet the needs of vulnerable/protected groups.

Care Homes

Positive Insights – What has Worked Well

Staff in care homes who have managed to limit the spread of COVID-19 within the home cited good leadership, willingness of staff to be flexible, making proactive contact with advocates and acting before government guidelines came into force as reasons why they achieved this.

Healthwatch Sheffield heard positive stories about many care homes that are supporting residents to speak to their relatives and advocates. Many care homes have begun using video calls, supporting phone conversations over loudspeaker or conference calls.

Lessons Learnt – Areas for Improvement or Further Exploration

Staff shortages were felt most at the beginning of lockdown, however this subsequently improved. Linked to staff shortages, some staff members are feeling under pressure to go into work when they are unwell or shielding.

There was mixed feedback about working with GPs, with some being supportive, while others reportedly being unwilling to visit care homes even when residents are very unwell. Healthwatch Sheffield heard from one advocate that communication with relatives had been an issue, such as where a relative had not been given information about their loved one's death.

Building on Our Learning – Our Recommendations to Take Forward

- Establish clear guidelines for staff as to whether they need to go to work if they are unwell or shielding.
- Establish clear guidelines for GPs as to whether they should go into care homes to treat patients.
- Learn and widely share best practice from care homes that have coped best during COVID-19.
- Increase use of technology for patients to talk to family and friends.

Communications

Positive Insights – What has Worked Well

In general, patients have found it easy to find COVID-19 information. For instance, 42.8% of Healthwatch Rotherham respondents found it very easy to find information and only 23.8% of Healthwatch Nottinghamshire – Bassetlaw respondents had unmet information needs. In fact, the majority (52.9%) of Healthwatch Rotherham respondents said that they had seen 'Too Much' COVID-19 information.

Patients found radio/TV/newspaper news, online resources such as national organisations' websites (e.g. Government, NHS) and local statutory organisation websites (e.g. Barnsley Council, Barnsley Hospital NHS Foundation Trust) as the best sources for COVID-19 information.

Lessons Learnt – Areas for Improvement or Further Exploration

Topics that service users have found difficult to get clear information about include: testing for COVID-19; face coverings; advice for family carers; social distancing; the rules when presenting to Accident and Emergency; and access to patient transport services. Misinformation is widespread, especially online, with the rate of sharing incorrect information considered of high concern.

The Rotherham Ethnic Minority Alliance found that reliance on digital distribution of information has left a lot of unmet information needs, in particular those for whom English is not a first language. High rates of illiteracy mean that written material is not always helpful, irrespective of the language.

Service users also reported that the application of 'shielding letters' seems inconsistent, with some respondents saying they had been expecting a letter but then not receiving one. On the flipside, some service users heard they had been designated as 'shielding' by their doctor without making it known to them previously. There is also evidence that some people are receiving shielding letters late (several weeks after the first national lockdown had begun).

Building on Our Learning – Our Recommendations to Take Forward

- Continue to promote national and local NHS/ National Guardians Office (NGO)/statutory organisations' websites as sources of COVID-19 information. Sustained activity to promote accurate public health information from trusted sources will help keep SYB's communities informed of the latest Government and NHS advice, whilst mitigating the negative impact of inaccurate news sources.
- Adapt information for vulnerable groups to ensure full accessibility compliance, including Easy Read formats, audio versions, translated texts and other visual and disability-friendly formats.

Digital Changes and Innovation

Positive Insights – What has Worked Well

Feedback regarding telephone consultations has been positive, particularly when there has been clear communication, follow-on action and the opportunity to ask questions (especially by patients who are hearing-impaired). Patients appreciated having the choice (where there was one) between telephone and face-to-face appointments.

Lessons Learnt – Areas for Improvement or Further Exploration

People with long-term medical conditions have found it difficult to access the medication they need due to changes in prescription processing at some GP practices. Patients that would have previously visited their practice to collect prescriptions have since had to find new ways of getting their medications – such as emailing.

There is also a digital divide in communities that are economically or socially deprived. Vulnerable groups across SYB that are unable to afford laptops, connection to the internet or data services are less likely to gain access to information they need. As a result, children in these circumstances are at a greater educational disadvantage given the greater prevalence of online lessons. This means affected pupils might be more likely to fall behind compared with their peers.

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 health or socioeconomic need.
- Adapt the care administered depending on a patient's ability to use technology.

Mental Health

Positive Insights – What has Worked Well

On average, respondents reported that they were coping well with their mental health. For example, 75% of Healthwatch Barnsley respondents said that they did not feel that they needed support (with their mental health). The report also found that 11% had used a website (or app) such as a mood tracker or mental health support groups on social media.

The Rotherham Ethnic Minority Alliance has been looking into offering faith-based counselling and community-based initiatives to support vulnerable communities, particularly those from a Black, Asian and Minority Ethnic (BAME) background. Mind (mental health charity) is also offering bespoke therapies for members of the Armed Forces and their families.

Lessons Learnt – Areas for Improvement or Further Exploration

Healthwatch Doncaster found that COVID-19 has added to the stress and anxiety experienced among asylum seekers. With the Doncaster Conversation Club (DCC) currently remaining closed, asylum seekers are often without places to provide sufficient refuge or dedicated support.

Sheffield International Venues and Links School Sport Partnership report that the lack of access to healthcare services and unmet healthcare needs have taken a toll on young disabled people who report feeling depressed, anxious, unfit and lacking in confidence.

In terms of bereavement agencies, there were reports of a lack of appropriate support, with recognised services being overwhelmed. Mind Bereavement Support (funded by Age Better) provides a service limited to communities in Lowedges (Sheffield) for which funding is due to expire in March 2021. Faith-based communities, particularly those holding Muslim and Jewish beliefs, found it difficult to undertake burial rituals as part of restrictions on funeral arrangements.

Building on Our Learning – Our Recommendations to Take Forward

- Faith-based counselling services can be effective for some communities who have been largely affected by COVID-19.
- Increase the level of support for vulnerable communities in SYB, including asylum seekers, required during the pandemic.
- Secure additional funding for bereavement services.

Patient Safety

Positive Insights – What has Worked Well

In a case study of a 77-year-old female patient with several health conditions, Healthwatch Doncaster reported that the patient received excellent care when visiting a sister practice in Harworth. Nurses and patients all wore Personal Protective Equipment (PPE), with plenty of hand sanitiser available. The patient was able to enter and leave the practice without any contact with other patients.

Skilled members of the asylum seeker and refugee community have made face masks for members of DCC. Over 300 of these have been distributed to asylum seekers and volunteers for free. Sheffield Health and Social Care NHS Foundation Trust (SHSC) are exploring ways to get health checks for BAME staff who have not previously been identified as within a vulnerable group, as well as for staff living with vulnerable relatives.

Lessons Learnt – Areas for Improvement or Further Exploration

Some care homes were able to stock up on PPE in March 2020, but reported to Healthwatch Sheffield that these supplies are now diminishing and that they are struggling to source more.

Cancer patients have concerns regarding delays, changes and unavailability of services, as well as fears of attending services in-person during the pandemic due to a fear for their safety.

Members of the population were sometimes unaware of their own health risks due to the pandemic; 3.8% of Healthwatch Nottinghamshire – Bassetlaw-based respondents did not know they were in the highest risk group and 10% did not know they were in the increased risk group.

Building on Our Learning – Our Recommendations to Take Forward

- Source and provide reliable supply of PPE for staff working in care homes where their sources are often likely to run low.
- Ensure cancer patients feel safe when they attend necessary appointments.
- Utilise the skills of workers from vulnerable communities who may be out of work so that they gain empowerment and the opportunity to contribute to the response.

Vulnerable and Protected Groups

Positive Insights – What has Worked Well

Healthwatch Doncaster's Case Study of the Asylum Seeker and Refugee Community reported that GP appointments have been accessible over the phone using a telephone interpreter service. This service is provided as and when needed, and organised by the GP practice. SHSC are implementing the Attend Anywhere platform for video consultation, which includes interpreters of different languages.

Lessons Learnt – Areas for Improvement or Further Exploration

Reports highlighted the disproportionately high mortality and/or diagnosis of COVID-19 for Black, Asian and Minority Ethnic (BAME) groups, people living in the most deprived areas, people who are clinically obese and men.

Particular concerns include: the compulsory wearing of PPE making it more difficult to communicate with patients who rely on non-verbal communication; vulnerable women not seeking medical care for fears of being exposed to COVID-19 (or did not know phone consultations were available); increased suicidal thoughts among men from BAME backgrounds due to insecure employment and incomes; ensuring the safety of people with Learning Disabilities who did not fully understand the risks of COVID-19; Lesbian, Gay, Bisexual, Transgender/ Transsexual plus (LGBT+) groups needing to move in with family who may be homophobic or otherwise unaccepting of their identity.

In Healthwatch Sheffield's report on refugee and asylum seekers' access to services, the highlighted concerns include: NHS charges deterring people from seeking essential healthcare; the psychological

impact of lockdown on people in low-quality accommodation; the issues around being physically or emotionally isolated; and potentially having a history of trauma (including imprisonment)

Building on Our Learning – Our Recommendations to Take Forward

- Ensure face-to-face communication is adapted to those who rely on non-verbal communication.
- Promote phone consultations to vulnerable women so that they access care.
- Provide clearer and more accessible communication messages to people with Learning Disabilities, especially relating to public health guidelines.

Wellbeing

Positive Insights – What has Worked Well

Vulnerable groups in SYB have been trying to keep well both physically and mentally through participating in a range of activities such as gardening, exercise, housework, keeping in touch with friends and family (online or by phone).

There are indications of more charitable behaviour across SYB communities. Since the crisis began, the feedback received suggested people were giving more money/resources to charities and helping friends, family or neighbours with errands (food shopping and other needs).

Older people with health conditions that identify as being confined to their houses report that they are missing the routine of their old lives. However, some respondents appreciated positives like being able to enjoy spending time with their partners and a noted perceived improvement in neighbourhood spirit.

Lessons Learnt – Areas for Improvement or Further Exploration

Since the pandemic began, there has been an increase in domestic abuse and risk of violence (including from loan sharks and drug dealers in lower socioeconomic communities). These incidents and encounters are harder to evade during lockdown, noted as an area of concern from within BAME communities.

The National Carers UK report showed that 70% of carers are providing more care since the crisis. The majority (55%) of carers agreed or strongly agreed with the statement, "I feel overwhelmed and I am worried that I'm going to burnout in the coming weeks". Some respondents felt that key day services had been closed during the initial outbreak. Specialist provisions have been particularly hard to access for certain groups, such as those caring for a person with a Learning Disability such as autism, or a person with dementia.

Building on Our Learning – Our Recommendations to Take Forward

- Protection services should be more widely available for people at risk of domestic abuse, threats of harm and violence.
- Enhanced support for carers of particularly vulnerable groups that require access to 24/7 care.

Chief Clinical Information Officer (CCIO) Interviews

5

Introduction

This short summary report details the feedback and recommendations from a series of short interviews undertaken with Chief Clinical Information Officers (CCIOs) from across South Yorkshire and Bassetlaw (SYB).

The role of CCIOs is to act as a point of liaison to support the strategic aims of the organisation. Acting as a coordinator between various disciplines, a CCIO will oversee the organisation's responsibility for the clinical adoption of technology with a keen interest in pursuing organisational reform. Through sustained and continuous improvement, a CCIO will bring together the disciplines of clinical information, use of technology, leadership and data efficacy to support their employee organisation.

Having the interest and support from across CCIOs within SYB has been crucial in shaping the understanding of the full extent of the impact caused by COVID-19.

Through the accelerated adoption of new innovations and technology, the SYB ICS has been able to capture the rich insights of CCIOs, enabling for best practice and learning outcomes to be defined.

The CCIO interviews were conducted over a short time frame (July 2020) with 10 participants interviewed in total. Interviews were led by Ben Gildersleve (Digital Programme Director, SYB ICS) and supported by colleagues from the digital workstream and the Yorkshire & Humber AHSN.

Interviews followed a consistent, semi-structured approach with each conversation lasting around one hour in total.

Themes that emerged from the CCIO evaluation interviews include:

- Democratisation
- Digital supports productivity
- Flexibility and choice
- Rapid delivery
- Remote working and impact on people
- Sharing good practice
- Sharing patient information from multiple sources
- The basis of future delivery

One pivotal outcome arising from the CCIO interviews is the proposal to develop a network of CCIOs (and other health and care leaders interested in digital) across South Yorkshire and Bassetlaw. This is an exciting development and one that could reinforce our understanding of rapid insights as the project moves forward.

Summary

Positive Insights – What has Worked Well

"A decade of progress in two months."

- Motivation for change – we heard that there was a keen interest to progress on this rapid-change journey facilitated by greater trust. On the whole, respondents had not experienced this feeling so clearly or visibly before. New technology and the motivation to use it (often out of necessity) among both patients and staff, is seen as an essential part of health provision going forward.
- Being able to share patient notes and obtain information quickly from acute or outpatient settings has been invaluable for clinicians (and the wider workforce). Pre-pandemic the default approach was to have paper-written notes, and clinicians had to work with partial information. There is a strong sense that this should not be the case going forward.

"From Mexico to Scunthorpe."

- Anecdotally, the majority of patients and relatives have welcomed, embraced and praised the technology on offer. Since it allows maximum flexibility, and removes any geographical barriers, relatives were able to be involved in patient care irrespective of their geographic location. The use of video calls enabled patients to see their relatives. This provided a welcome opportunity for interaction at a time when strict lockdown policies around visitation rules were in place.
- The ability to attend meetings virtually by working from home has allowed an unprecedented level of flexibility. On the whole, staff across the system have embraced this new freedom which has acted as a 'leveller', allowing for greater inclusion (since it removes any geographic bias). We also heard that engagement in meetings has been high as a result.

Lessons Learnt – Areas for Improvement or Further Exploration

"What happens when it's not there?"

- Unplanned system downtime sometimes meant that clinicians and other healthcare staff were forced to revert to paper notes. This is not a viable solution going forward.
- Some GP practices still do not have access to ward notes and this is an ongoing issue. Whilst there have been enormous strides towards improving the working relationship between primary and secondary care, overall there was a general feeling that 'we aren't there yet'.
- Respondents felt that the procurement and distribution of laptops and equipment was slow at times, and the equipment itself was not always suitable for the job (such as slow-performing laptops). Additional useful hardware (such as camera equipment) remained unused in offices. At times, there was a noted lack of oversight of resource.

"We take for granted that everyone can do it."

- We heard that clinicians are worried about vulnerable groups and the digital inequality as we move into a digital-first model of care. An example given was of an elderly lady who struggled to point the camera at her foot during a consultation – this meant the appointment took 15–20 minutes longer than it should have. Meanwhile, vulnerable groups, such as asylum seekers, may not have access to digital devices (smartphones). The patient literature sent out to support virtual consultations was, in one case, provided in English rather than the patient's preferred language. We heard of similar concerns about whether some individuals in society were being 'missed'.
- Furthermore, from a workforce point of view, there was (and remains) a great variation in staff skills when it comes to IT – some doctors, for example, are able to touch-type whilst talking to patients, whereas others find typing more difficult. This slowed-down the process for some who would have preferred dictation or another solution, which was not available to them at the time.

"It can be a lonely world for some."

- From a staff perspective, remote working was considered by some to have reduced some of the social benefits of an office environment. Whilst working from home was perfectly acceptable to staff who had adequate workstations, others were impeded by inadequate broadband (internet) connection, phone signal issues or a suitable work area to establish as their 'home office' set-up.
- From a patient perspective, most respondents were praising of telephone and video consultations. However, there were still concerns that remote consultations were not always the most appropriate format. As an example, in Paediatrics it was found that children under eight years old struggled to use Zoom (video call platform), whilst in Child and Adolescent Mental Health Service (CAMHS), teenagers anecdotally preferred the Attend Anywhere platform. This was because the teenagers could be in their own home environment, in which the clinicians found that sometimes parents might choose to leave the room (and even the house) whilst the call

was taking place. In these instances, the flexibility of the format meant that parental and guardian input was absent when it would have been helpful to the consultation.

Building on Our Learning – Our Recommendations to Take Forward

"Emphasis on the 'national' in National Health Service."

- Respondents were keen to stress that moving forward there needs to be a standardisation of IT applications to ensure patient confidentiality and safety – but also to ensure a more simplified clinical exchange. Whilst major positive changes have taken place on a localised level, including some excellent direction from command structures now in place, discrepancies over agreed IT software choices and protocols could lead to a potential slowing down of otherwise rapid progress. For example, one hospital department uses their own preferred clinical communications platform, whereas a closely related department uses an entirely different platform. Consequently, there is a risk that 'optional' and selective decisions concerning IT communication platforms will make information sharing, and ultimately collaboration, more complicated in the future. Addressing these obstacles now, before any technology becomes too embedded in practice, would be beneficial.
- Given the increased reliance on communications technology, national funding schemes and caps on licenses for software (such as Microsoft Teams) should be an area of importance going forward. Equipment and IT hardware also needs to be reviewed regularly and replaced systematically. This is considered more important now that health and care services rely heavily on these products functioning effectively.
- A 'back-up plan' for infrastructure failure was a topic of discussion among several respondents. There were queries about contingency plans for IT failures, which in the current pandemic circumstances would present very few viable alternatives to fall back on.

"Protect clinicians' innovation to drive change."

- Respondents were overwhelmingly resistant to reverting back to old pre-pandemic ways of working. In particular, the sense of trust and rapid decision-making has enabled significant change and fluidity – something that staff would like to see continue. It is apparent that 'going back' to previous modes of working, referred to as 'overthinking', would be unwelcome.
- Whilst a motivation for change is high, many expressed concerns that the governance surrounding change should be strong and accountable to ensure that all groups' needs, considerations and preferences are heard.


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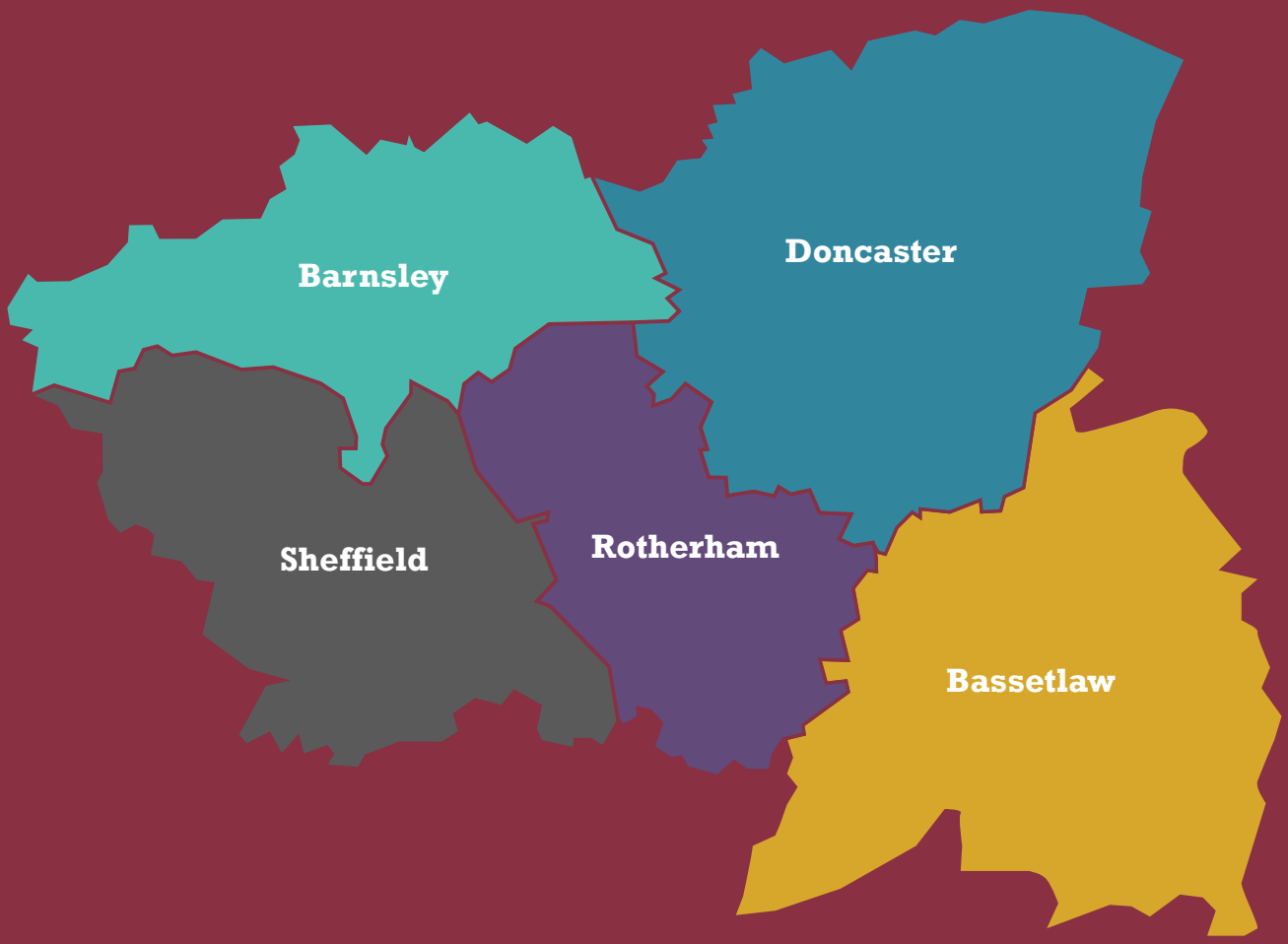

Barnsley
Doncaster
Sheffield
Rotherham
Bassetlaw

Case Study Interviews 6

Introduction

As health and care organisations within the NHS and across SYB were preparing for the enormous challenges of managing COVID-19, it became clear that services needed to change, adapt and modify their existing work practices to effectively manage this new threat.

The Yorkshire & Humber AHSN quickly set up an Evaluation and Reset programme as a means of capturing insights, developments and rapid transformation. This was to build an intelligence base which the ICS and health and care organisations across SYB could utilise as part of ongoing learning and continuous improvement.

As part of this work, the Yorkshire & Humber AHSN conducted case study interviews with a number of key healthcare professionals across SYB ICS. The interviews aimed to gather insights about the new adaptions and innovations that have taken place during COVID-19. Specifically, interviewees were asked to provide their honest feedback about: successes and challenges; areas of transformation that should be continued or discontinued; behaviours and skills developed; and questions around sustainability and future viability.

Yorkshire & Humber AHSN also conducted interviews with SYB ICS Programme Directors (PDs) to deeper capture insights from within ICS' dedicated workstreams. PDs reflected on how their roles had changed due to COVID-19, the initial pandemic response (including digital transformation), and the patient and public experience. PDs unique perspectives provided rich viewpoints in which these interviews produced valuable insights, of particular use for SYB ICS' Innovation Hub (IH) in their parallel ongoing evaluation work. The IH continues to support SYB's health and care system in its digital transformation objectives (see ICS Five Year Plan 2019–2024).

In terms of the role of a PD, their core responsibilities are to provide leadership across the workstream. Ensuring that ICS programmes are carefully managed and delivered to a high standard, PDs also ensure there are clear measurable objectives which underpin their area of work within a robust governance structure. PDs play an integral role in working with colleagues to support the culture, values and objectives of ICS partners. In doing so, PDs can provide assurance and guidance towards shared outcomes, facilitate strong alignment to these system-wide objectives and help to sustain effective collaboration towards the delivery of key transformation programmes across SYB.

These interviews were conducted between August and September 2020 and led by the Reset and Evaluation Programme Team at the Yorkshire & Humber AHSN.

The case study reports referenced in some of these interviews can be found overleaf.

Technology and Remote Working

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

Approach and Methodology

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

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

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

Impact

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

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

The Stroke Hosted Network was able to quickly share learning across the system – and beyond – through webinars and workshops. Through video platforms such as Zoom and Microsoft Teams, the first webinar on remote technology was delivered in partnership with accuRx. The session had over 100 attendees from across the country. The second webinar, which focused on the evidence base for remote technology in rehabilitation, had approximately 300 attendees. It is clear that the high number of attendees and participations may not have been achieved under normal pre-pandemic circumstances.

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

Next Steps

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

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

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

Key Learning Points

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

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

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

Testimonial

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

SYB Stroke Hosted Network Manager

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

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

Partnership Working for the Shielded Population in Barnsley

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

Approach and Methodology

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

The NHS work for this identified people on the shielded list, they were advised what shielding meant, how to do it and how to access support. Care plans were reassessed and advice on how to access appropriate services was given to minimise the risk of infection exposure.

Impact

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

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

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

Next Steps

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

Key Learning Points

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

Interviewee: Joe Minton, NHS Barnsley Clinical Commissioning Group.

Changes to the Emergency Department

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

Approach and Methodology

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

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

Impact

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

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

The suspension of some services, such as elective surgery, also enabled the expansion of additional facilities to support social distancing and separation of respiratory (and non-respiratory) patients. The reallocation of staff, who would otherwise have been working on these closed wards, supported this infection control activity. With services restarting, there are ongoing challenges to manage to the hospital site to maintain safe distancing, but this is carefully resolved through stringent infection control processes.

Next Steps

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

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

Key Learning Points

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

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

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

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

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

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

Approach and Methodology

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

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

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

Impact

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

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

The interviewee is a consultant working predominately in the community with day-to-day dealings with the hospital. As visitations were heavily reduced, our interviewee and their clinical team were able to support in the Palliative Care Ward instead. During the height of the pandemic the team was able to support with ward rounds, freeing-up hospital consultants for more urgent care.

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

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

Next Steps

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

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

Key Learning Points

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

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

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

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

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

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

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

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

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

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

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

Approach and Methodology

Mental Health Patient Assessment

The team included a Consultant Psychiatrist, a Social Worker from the Local Authority and a Mental Health Act Manager. In the early stages of the lockdown, this team examined all the legislation, case law (such as The Human Rights Act, 1998) and other relevant polices and legal guidance. The team sought legal advice and were able to use a previous case study example supplied by the Local Authority, which they could draw as a basis with which to follow safely in these new unprecedented circumstances. Together, this team devised a 10-page document within one week, to ensure that they could safely resume mental health assessments in a legally compliant and patient-centred manner.

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

This document enabled the team to stipulate clear guidelines including key safeguarding measures but also practical elements, such as the adaptions for patients authorising consent (or signing of) documents electronically. These swift, practical measures reduced the threat of infection by

ensuring that social workers only needed to deliver documents digitally to the hospital (but not in a physical capacity).

Changes to Medication Protocols

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

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

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

Impact

Mental Health Patient Assessment

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

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

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

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

Changes to Medication Protocols

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

Next Steps

Mental Health Patient Assessment

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

Changes to Medication Protocols

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

Key Learning Points

With the service disruptions and risk-to-patients caused directly (and indirectly) by COVID-19, the

innovation that enabled mental health assessments to continue has been highly positive and motivational.

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

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

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

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

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

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

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

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

Adult Speech and Language Therapy in The Rotherham NHS Foundation Trust

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

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

Approach and Methodology

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

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

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

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

Impact

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

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

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

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

Next Steps

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

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

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

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

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

Key Learning Points

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

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

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

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

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

Digital Care Homes

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

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

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

Approach and Methodology

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

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

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

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

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

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

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

Impact

Doncaster CCG has received very positive feedback about iPad deployment and care home staff as key stakeholders in their virtual locality MDTs.

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

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

Next Steps

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

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

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

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

Key Learning Points

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

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

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

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

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

Testimonial

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

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

Interviewee: Katie Dowson, Place and CCG Digital Director, Doncaster CCG.

Clean Digital Clinic and Telehealth

The position of Director of Recovery is a new temporary position created in order to focus on recovery, reset and transformation.

Approach and Methodology

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

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

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

Impact

The immediate impact was supporting ongoing care to those who:

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

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

Initial barriers were experienced, most notably a slower-than-expected uptake than was anticipated. Since then, increased promotion and awareness of the initiative, ongoing testing and feedback, has seen an improvement in uptake.

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

Next Steps

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

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

Testimonial

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

Wider Areas of Learning

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

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

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

Increasing care in the community was supported by the initial redeployment of staff to manage increased demand. Around 100 staff in total were redeployed at the peak of the initial pandemic surge.

From a sustainability perspective, they want to use the learning seen from the pandemic and work with commissioners and partners to define what services should look like to deliver this ambition longer-term. It is also critical to maintain this position culturally as the major incident catalyst starts to subside and with it the risk of shifting back to traditional ways of working.

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

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

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

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

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

Interviewee: Sarah Bowman, Director of Recovery, RDaSH.

Technology and Electronic Prescribing in Barnsley

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

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

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

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

Approach and Methodology

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

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

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

The extra security was added to the system in the form of a virtual smartcard technology, provided by Isosec; the importance of which was heavily promoted during the pandemic, with the concern of frequent cyber threats.

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

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

This form is then submitted to the Dispensary, which has a dashboard for monitoring incoming prescriptions. The pharmacists are presented with two options: to accept or reject the prescription.

If a rejection notice is clicked, the pharmacist has to give a valid reason for the rejection (such as incorrect drug dose, possible drug interactions and stock issues). The prescriber is also able to review the rejected prescription, make the necessary changes and re-submit the form.

Impact

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

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

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

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

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

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

Next Steps

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

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

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

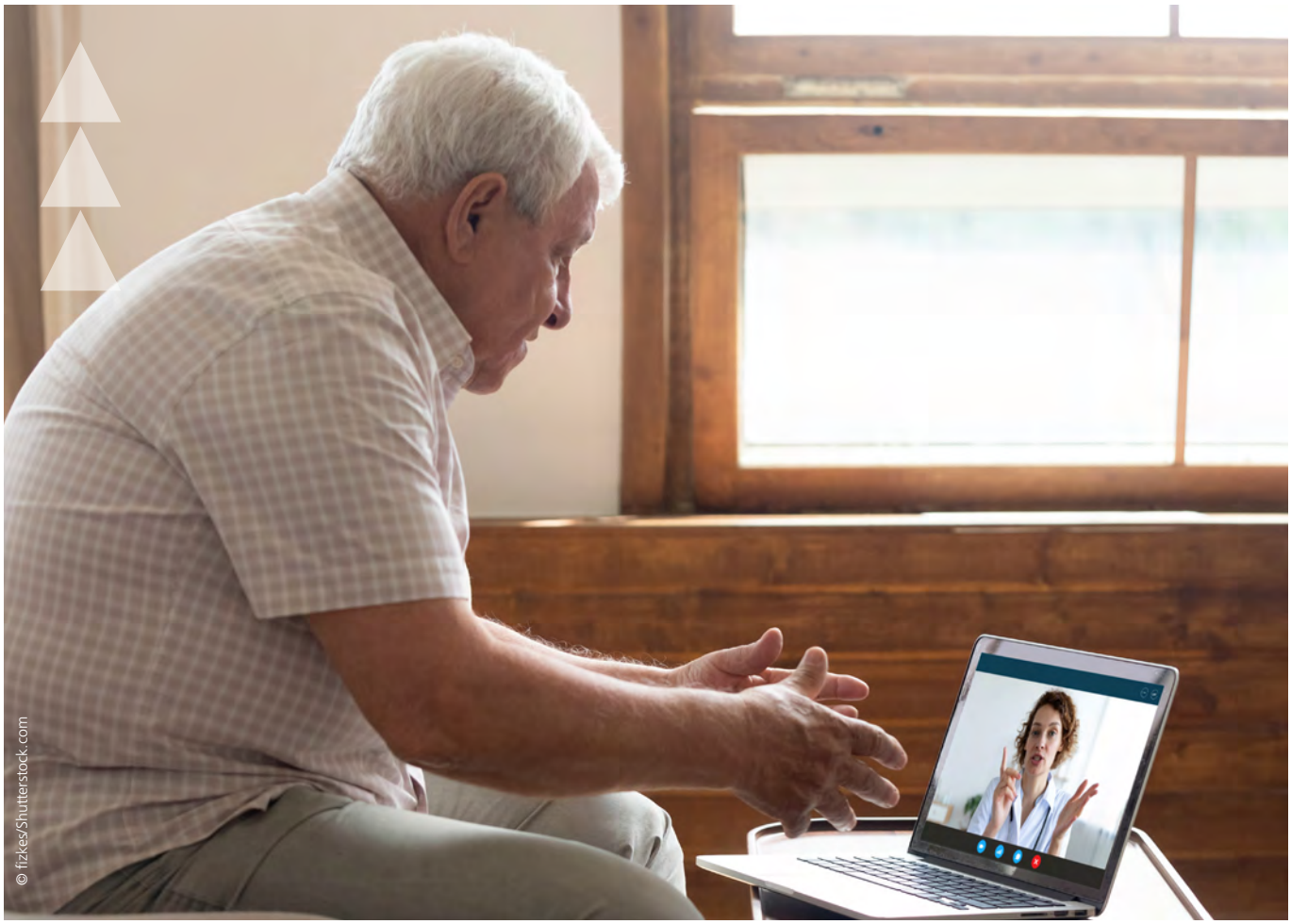
Key Learning Points

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

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

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

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



Programme Director Interviews 7

This short summary report outlines the feedback and learning from a series of interviews undertaken with Programme Directors (PDs) in South Yorkshire and Bassetlaw (SYB) ICS. The interviews were undertaken as part of a wider rapid insights initiative undertaken in partnership between the Yorkshire Humber AHSN and the SYB ICS.

The role of a PD is to provide leadership to ensure ICS programmes are run to a high standard with clear objectives, carefully underpinned by a robust governance structure. PDs collaborate with a wide range of colleagues across the health and care system, providing confidence and assurance of progress towards shared outcomes for the mutual benefit of all partners. Their support for the accelerated adoption of new innovations and technology has been crucial in supporting the SYB ICS response to the COVID-19 pandemic.

Capturing the unique insights of PDs has been essential in supporting this important rapid insights project. Their personal contributions ensure the sharing of best practice and learning outcomes will give a vital stage to a host of innovations that have kept health and care services going during one of the most challenging periods of the NHS' long history.

South Yorkshire and Bassetlaw's PD interviews were conducted over a short time period across August and September 2020. Interviews were led by colleagues from the Reset and Evaluation Workstream in the Yorkshire & Humber AHSN. Interviews followed a consistent, semi-structured interview approach with each interview lasting around one hour in total.

Positive Insights – What has Worked Well

"Never underestimate what people can do when faced with a crisis."

- There was a clear motivation for change; adopting new technologies and different ways of working highlighted that practical problems can be solved if there is commitment to find solutions.
- New workstreams that had been originally planned and assumed to take years to implement were able to materialise in a matter of weeks. COVID-19 had created the necessity to accelerate work, with the most successful results seen when organisations already had experienced the testing of their innovations on a lower level. This inevitably ensured that organisations could progress with their adaptions in greater confidence that they would work.
- Command and control was cited as being a key reason for the acceleration of the enhanced alignment between regional expectations and the ICS. Changes in governance, such as the reduced number of committees, meant that leaders were empowered to make decisions using their own judgement. Moving to a short-term block contract helped, because it removed money from conversations and became easier to deliver change.

"Digital innovation across all areas."

- Social distancing and enhanced infection control measures have resulted in many health and care settings embedding more digital technology into their working practices. As a result, clinicians have been able to keep communicating, monitoring

and consulting with patients throughout, which has been vital to keep people well. The central theme from this point being that there appears to be no reason why many of the digital adaptions cannot be kept in future.

- Remote working has proven popular. COVID-19 meant that a digital-first approach became a necessity. However, there are real concerns around staff not having adequate IT in order to work from home effectively, whether that is due to workplace set-up (Display Screen Equipment compliance), provision of hardware (laptops) or internet connectivity.
- We have heard that the ICS has been working with colleagues in CCGs to discuss the challenges and priorities for digital healthcare initiatives. There is an opportunity to translate these insights from this report into tangible objectives; this report will provide a range of case studies across different healthcare settings and among different areas of NHS workforce.
- Digital is also being used to deliver training to staff so that distancing is maintained.

"Microsoft Teams has been brilliant."

- Video meetings enabled fluid communication between staff across the system. A theme that resonated loudly was the savings on staff travel times. It meant people were available, both in terms of physical presence to attend meetings but also more willing to make the effort to attend given travel was no longer a barrier. Microsoft Teams enabled easy collaboration within smaller teams but also cross-organisationally, which naturally led to more effective system working.
- Video meetings meant that PDs in the ICS were able to re-establish close alliances and stronger partner relationships, especially with front line clinicians who previously had more competing demands on their time. Online meetings are said to feel more focused and, as a result, have enabled greater collaboration between attendees with a new-found focus. It is important to sustain these much-improved relationships and

Page 30 – the standfirst text is a repeat of first paragraph. the sense of unity and shared endeavour to problem solving that has been a core part of COVID-19.

- There was praise for the ICS' clear, frequent communications, providing system-level updates on the COVID-19 position in SYB. These updates provided a useful snapshot of the work taking place across different workstreams, news from across SYB's partner organisations and among leadership and executive group priorities.

Lessons Learnt – Areas for Improvement or Further Exploration

Patient and Public Engagement

- A number of providers have conducted patient questionnaires about virtual consultations, with feedback mostly very positive (70–80% satisfaction). However, it is important to still remember the wider needs of diverse communities across SYB, in which digital exclusion must be considered, alongside the minority that reported a negative experience from using remote technology.
- It is vital to find a consistent and effective way of getting feedback from citizens. The ICS is working with other organisations, such as the Cancer Alliance, which can support patient engagement activity.
- Public confidence in visiting hospitals remains low, affected by the perception of being susceptible to infection from COVID-19. Our insights suggested

that some patients deliberately chose to delay operations "until COVID-19 is gone". With COVID-19 likely to remain part of the healthcare picture for some time to come, it means that more sustained public-facing communication to provide reassurance is needed, explaining how hospitals are safe and important to continue using as required.

Speed of Changes

- The rapid implementation of digital innovation across SYB has meant changes have often been adopted at speed, and therefore, more easily than in pre-pandemic times. Whilst clinical and technical rigour has still been applied, there has been less engagement in these rapid adaptions than would normally have taken place. As a result, there may be knowledge gaps and inconsistencies across SYB due to the speed of implementation.
- The pace of change sometimes meant that the usual evidencing and recording of the decisions had not been noted. Clearly, this is an example of the lightning pace of change that was needed on rare occasions to enable staff across the system to do their jobs.

Digital

- A key test for digital innovation across the system is training staff how to use new software, information systems and hardware effectively. Learners would previously have attended in-person training, sat beside a trainer and fellow attendees. Due to social distancing measures, the new obstacle of learning is how to use new technology 'via technology'. There is a risk that some people might not be adequately trained in order to maximise the capabilities of the technology in use.
-

Extensive remote working (from home) has created an estates conundrum, leading to questions about best use of buildings and resources within them across the patch. Many employers will see the opportunities of freeing up their estates and ongoing related costs if employees can continue working safely and effectively from home instead.

Building on Our Learning – Our Recommendations to Take Forward

"Exhausted, overwhelmed and overworked."

- The pressures of COVID-19 have left some staff "exhausted, overwhelmed and overworked". It is important to not underestimate how traumatic COVID-19 has been for the wider workforce. As services are working hard to restore 100% of activity, there continues to be high pressures and demands on staff. It is an important point to acknowledge, with the respect and consideration of the sacrifices and ongoing demands that might prevent staff from being motivated to do 'extra' work.
- On this same point, those that reported feeling the strain and pressures are reluctant to start further new projects beyond those that were already started or in-process before – and during – the pandemic. There is a sense that people would prefer time to embed the changes they have been working on, rather than introducing yet more systems and processes which might create even more work for them in the short-term.
- Disruptions to workforce, such as the trainee nursing associate cohort due to start 1st April

2020 being delayed until October 2020, will be six months late in joining the workforce. This will add additional pressures to staffing.

"It all comes down to the basics."

- A number of recent innovations that have been implemented during COVID-19 have been inspiring and effective, yet the basic needs around adequate workforce (numbers and skills) and space remain the most integral to the delivery of high-quality healthcare. These were challenges before COVID-19 and will continue to remain so in the future.

- Like other areas of healthcare, digital also needs to get the basics right, especially in terms of its application within health and care settings. For example, if the necessary information – digital or otherwise – is not in the hand of the clinician when they need it most, they cannot work effectively. A common theme was the suggestion of funding to fix digital problems – as they are (in essence) patient care issues.
- Patient expectations will need adjusting if digital technology is going to be fast-tracked even further across health and care. For example, GP appointments might move to a digital-first assessment. Whilst we should certainly progress with the adaptions that have worked, we must not lose sight that some patients and cohorts will want a return to pre-pandemic care in exactly the same way. Messaging around what the new health and care landscape might look like will need careful and sensitive communication.
- Despite all the innovations that have taken place during the pandemic, there is still no basic default health and care record that is used consistently by SYB health and care professionals across the region. It was stated by some respondents that developing this information system is (more) vital if healthcare in SYB is to be delivered in the most effective way possible.

Inequalities

- Whilst digital innovation often supports wider access opportunities through adaptive technology, a key issue remains around digital exclusion. There are a number of communities in SYB that do not have digital devices (smartphones or tablet computers), reliable internet connectivity, skills to support IT issues (in the home) or the latest software. The NHSE/I blueprint is looking at progressing with a digital outpatients process which aims to be rolled out widely. However, there still needs to be mitigations as this should not be the only way of accessing care, especially within SYB.

- As widely reported, COVID-19 is likely to have a significant and detrimental impact on wider economic inequalities, unemployment, secure employment (such as casual and fixed-term work) and insufficient housing environments. These are often referred to as the wider determinants of health and, due to their complexity, it requires cross-sector collaboration (Local Authorities, voluntary sector and City Regions etc.). The NHS will still need to ensure fair and equal access to services, manage waiting lists and prioritise patients, regardless of the digital blueprint agenda.

Summary and Recommendations 8

In order to fully understand and evaluate the impact rapid innovation has had across SYB, The Yorkshire & Humber AHSN and South Yorkshire and Bassetlaw (SYB) ICS examined a huge range of rich data.

By collating the first-hand experiences and insights of a diverse cross-section of SYB's health and care workforce, this comprehensive thematic analysis will support further international research into the impact of COVID-19 on global healthcare systems.

Through our close involvement with health and care leaders, PDs and frontline staff, we have been able to define important key learning outcomes to drive forward future innovation and change.

A summary of the key findings of this report are as follows:

- **Virtual remote-working is seen as a positive**
  - The flexibility it has afforded contributes to staff wellbeing. Flexibility over remote working led to additional time-saving benefits, from reducing commutes to and from work, to meetings and enhanced work-life balances. It has also supported greener lifestyles due to reduced use of transport. Some of the challenges include a greater a blurring of work-life priorities, inconsistent performance and access to effective technology and inefficient scheduling of meetings.
- **The use of technology to deliver healthcare services was well-received by patients**
  - It ensured improved continuity of care, more flexibility in delivery of services and improved accessibility. For staff, it allowed rapid upskilling (where an urgent need was identified in the workforce) and provided new practical yet inventive ways to support their patients remotely (without suspending care completely). However, some patients did not have access to the necessary technology or IT equipment, meaning service delivery sometimes took time to integrate fully.
- **COVID-19 has led to a greater collaborative approach across the region**
  - The pressures on health and care services led to an enhanced 'in it together' attitude, leading to a notable increase in trust between partners, improved communication and knowledge sharing, and greater recognition of specific team contributions across the wider system. Nevertheless, increased communications between and amongst teams sometimes created 'information overload' alongside an unnecessarily large number of additional meetings.
- **Patients had the best experiences when their access to healthcare was least disrupted and their safety was protected.**
  - At the heart of all this work, the provision of medicine, e-prescriptions and video consultations limited the patient risk of exposure to COVID-19 whilst also sustaining key services.

- **Noticeable shift in positive behaviours**
  - The willingness to be supportive and flexible across the workforce, better communications and connectivity between teams and organisations, greater appetite for change and a more resilient attitude to setbacks are the main learning outcomes. However, some respondents missed the office environment, whilst there was a feeling of insecurity for staff on casual or fixed-term contracts.
- **Leaders have been visible and supportive**
  - From flexible working to bringing greater clarity to teams and their unique roles, leaders have been more accessible. They have supported colleagues with the challenges and complexities by helping to define roles and expectations clearly during high-pressure times for the NHS. They have also facilitated cross-organisational collaboration and cross-system working. However, there was a noted lack of clarity and role expectation for new clinical leadership positions, which has been reported as being challenging to those affected.
- **Care home staff have valued system-level support and interventions when it was needed.**
  - Good leadership, willingness of staff to be flexible, proactive contact and acting on a regional footing (before government guidelines came into force) helped to support care homes from further pressures. These measures greatly helped to limit the spread of COVID-19 in these settings. However, linked to staff shortages, some care home staff members felt under pressure to go into work to support their teams when they were unwell or shielding themselves.
- **Patients found it easy to find COVID-19 information.**
  - With partners joining up to share key messages and delivering a steady volume of public health messaging, patients felt informed of the risks of COVID-19. However, some communications were reported as being inconsistent or inappropriate for certain groups. Misinformation from unauthorised or malicious groups is also widespread. This has been problematic in terms of how we protect the public from inaccurate or ill-informed advice, often without any clinical or public health merit, especially on social media.
- **COVID-19 has had a negative effect on some patients' wellbeing and mental health.**
  - As widely reported, COVID-19 has had a significant indirect adverse effect on mental health, with depression and anxiety rising sharply. Mental health has also been exacerbated from postponed or cancelled services which has caused increased distress for patients, especially those who had already been waiting. Of particular concern, older people confined to their houses, deprived communities, those at risk of domestic abuse and violence, and protected groups, have all been disproportionately affected.

Recommendations

Based on the key findings of the report, the following recommendations are made in relation to the next steps:

- **Workforce:** Staff should receive more support to work virtually. This should include addressing the need to monitor staff's wellbeing, support the appropriate assembly of home workstations (especially technology) and to continue trying to replicate the positives of office working, such as casual and ad-hoc conversations and team building activities.
- **Technology:** It is important to embed technology effectively through extensive funding and training, alongside providing digital access for patients without access to digital technology.
- **Partnership Working:** Ensure that partnership working continues in the same collegial approach going forward, including sharing communication and data as appropriate and working together to remove barriers that impact on cross-organisational working. Further attention needs to be given to engagement with the community sector and social care.
- **Patient Safety:** A holistic understanding of vulnerable households should inform future planning and priorities for any wider roll-out of digital health programmes.
- **Communication:** Keep communication lines open to maintain the general sense of non-hierarchical and inclusive atmospheres, and to maintain the momentum of change.
- **Leadership:** There is an enthusiasm for ongoing visibility among our health and care leaders who have inspired others through a more outwardly empathetic and sensitive management style. Through the ease of using Microsoft Teams, more frequent attendance among Leaders has also been beneficial on occasions where their presence would not have been possible.
- **Collaboration:** Learn and widely share best practice between care organisations during COVID-19.
- **Health Inequalities:** Adapt communications for vulnerable groups and those with additional information and language needs. There must be recognition that the provision of appropriate care, effective communication and timely treatment across our most vulnerable and protected groups will help to stem and minimise health inequalities from declining further.
- **Patient Voice:** Continue to keep patients up to date on changes to appointments, treatments and care packages. We must also engage and utilise the views and experiences of patients to inform any change, as well as offer them the choice of having online or face to face (if safe) consultations, depending on their preference and personal circumstances.

To sustain the level of innovation, transformation and responsiveness that has been demonstrated throughout SYBs rapid response to COVID-19, partners and organisations across the ICS should consider (but are not limited to) the following factors:

- Relaxed bureaucracy and streamlined governance allowed for a shared vision across the region and offered a strong sense of direction to drive forward the rapid change.
- Funding for new technology, software, equipment, and to support new pathways in place.

- Technology and connectivity, as seen with the success of Microsoft Teams, as well as the necessary digital infrastructure to support their usage – much of which depends significantly on reliable internet connectivity.
- Agility of workforce played a crucial role in supporting the system at a time it needed it most. When rapid change and decision making was necessary for continuation of key services, the willingness across the workforce to alter working patterns, adapt routine processes, work remotely or via redeployment to other areas of the system have been incredibly effective.
- Supporting the collaborative attitude. This was demonstrated from a willingness to share data and information as appropriate and compliant, and to share resources (including staffing).

Fundamentally, COVID-19 has driven health and care services to innovate and implement rapid changes while protecting patients and staff in an environment that was open to change and transformation. The pandemic became a shared challenge and inspired partner organisations to work together more closely and effectively than ever before.

Next Steps

This system level report includes:

- Learning from rapid insights
- Patient and public feedback
- Case study and facilitated discussion outputs.

The next steps will be the identification and delivery of Quality Improvement (QI) based sustainability workshops, exploring in further detail the impact of specific innovations that have been adopted in response to COVID-19. This will build on the questions arising about the longer term viability of these innovations being implemented more widely across the system.

As with the Rapid Insights Report, the system-specific QI sustainability reports will be brought together into a regional-wide summary report, highlighting the work already undertaken and presenting new outcomes from the QI sustainability activity.

A literature review will also be undertaken to help provide added context and a broader range of useful innovation insights from across the UK and globally.

Acknowledgements

We wish to thank everyone working in health and care across South Yorkshire and Bassetlaw for their dedication, enthusiasm and ingenuity over recent months in responding to the COVID-19 pandemic. The examples provided have given an opportunity to draw valuable insights into how the system quickly reacted to the pandemic. We appreciate the additional time given to our researchers and analysts in order to share these personal insights.

Finally, we want to acknowledge the work of the small team from the SYB Partnership and the Innovation Hub, and Yorkshire & Humber AHSN for managing the process and collating the information for this report.

Policy Context and Governance

The Yorkshire & Humber AHSN has led the coordination of the regional activity in partnership with the NHS England and Improvement regional team and the work 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 SYB Partnership steering group, reporting into the SYB Health Executive Group (HEG) and other forums as required/requested.

Thank you for reading.

South Yorkshire and Bassetlaw Integrated Care System

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