

# The First Wave

Perspectives and learning from the COVID-19 Pandemic



**PPL**

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# **INTRODUCTION**

# PERSPECTIVES ON THE PANDEMIC

## OUR SHARED AND INDIVIDUAL STORIES

### CLAIRE KENNEDY, SIMON MORIOKA

Claire Kennedy and Simon Morioka are co-founders and joint managing partners at PPL, a social enterprise that exists to promote better health, wellbeing and economic outcomes working with individuals, communities and the organisations that support them.

**In late January 2020 the first confirmed cases of COVID-19 were reported in the UK. By June 2020, our world had changed beyond recognition.**

Much has been made of the collective experience, of an event that both separated us from each other whilst enveloping everyone in an omnipresent, invisible threat.

And yet as the weeks and months have progressed increasingly there has been recognition that even whilst the pandemic simultaneously affected communities around the world, the experience and impact of the virus has inevitably been personal.

Everyone has both a shared and individual story.

**One of the most tragic elements has been the exacerbation of existing inequalities, and the way COVID-19 threatens to worsen these long after the first wave has passed.**

There is nothing unique or surprising about this.

Whilst the initial pace with which COVID-19 spread left many of us feeling helpless and traumatised when faced with the enormity of the threat, the probability and impact of such an event has had pandemics at the top of the UK National Risk Register for well over a decade.

In a pandemic, it turns out that many of the normal rules still apply.

Not least amongst these rules has been that socio-economic factors (what we like to describe as “the wider determinants of health”) continue affecting outcomes for individuals as significantly as anything we do in a medical or care setting.

**The following essays represent a range of personal perspectives of those who have worked through the crisis, including in support of key health and care services and the local communities they serve.**

There are many other perspectives and many other potential lessons to be learnt; we have tried to highlight some key areas, but also not to duplicate other existing resources and definitely not to speak for everyone.

Particularly, for first-person accounts of the experience of living through the pandemic, including from some of those hardest affected, we would encourage you to visit online National Voices’ excellent “[Our COVID Voices](#)”, referenced in [Charlotte’s piece](#).

**There is a huge amount of learning out there - it is incumbent on all of us to work to apply it.**

The COVID-19 outbreak represented the biggest challenge to the NHS since 1948 and led to a full-scale mobilisation of resources across health, local government, the voluntary sector and local communities in response.

By July, when it was judged that England had achieved stage 3 in the government’s timetable for easing lockdown measures, at which “re-opening of... higher-risk businesses and public places” could begin, ONS data shows that cumulative excess deaths had exceeded the five-year average by over 50,000.<sup>1</sup>

**How do we reconcile our justified pride in all of those on the frontline, and the lives they saved, with the terrible toll that the pandemic has exacted on them, and on families and communities across the UK?**

Only by reflecting on what went well, and what needs to change; and by “building back better”, can we show appropriate respect to all of those lost, and to all the sacrifices that have been made.

And if none of us have all the answers, we at least have a much better grasp of the potential for what is achievable, in previously unimaginably short periods of time, and an opportunity to make a difference in the months and years ahead.

1 - Number of deaths registered in England and Wales, including deaths involving the coronavirus (COVID-19) pandemic (7th July 2020) Statistical Bulletin, Office of National Statistics.

**PART 1**

# **LESSONS FROM THE PANDEMIC**

# NOT TOO LATE

## INTERNATIONAL LEARNING FROM COVID-19

### SIR JOHN OLDHAM OBE

Sir John Oldham is Adjunct Professor at the Institute of Global Health Innovation at Imperial College London. He is a GP by background and chaired the Independent Commission on Whole Person Care in 2014. He was previously a member of the National Quality Board for the NHS in England, and National Clinical Lead for Quality and Productivity at the Department of Health and Social Care.

**It is clear that some countries have fared far better in their health response to the COVID-19 pandemic, and the consequent economic impact has therefore been lessened.**

For example, at time of writing the rate of deaths from COVID-19 per million of population in South Korea is 5.7. It is 4.5 in New Zealand and 4.0 in Singapore. At the opposite end of the scale to date are Brazil (308 deaths/million), the United States (406/million), and embarrassingly, the United Kingdom (656).<sup>2</sup> We are “world beating”, but not in a good way.

**These differences are too large to attribute to differences in data collection or populations.**

Indeed, some of the population demographics are similar. It begs the question, what has made the difference? Paul Batalden said “Every system delivers exactly the results it is designed to give”, and so it is here.<sup>3</sup>

**An analysis of the measures put in place by the most successful countries demonstrates some common principles.**

- 1. They approached the pandemic for what it is: a SARS-style virus, not a flu virus.**

That matters. Flu is less deadly and more well-understood, and epidemiological models of flu are based on more accurate data.

The opposite is true for COVID-19. Experience of SARS mattered more in these countries’ responses. It engendered a faster and more urgent implementation of measures judged to combat spread. I use the word “judged” deliberately. These countries used available evidence but based decisions on precaution. Waiting for immaculate science engendered delay. Basing decisions on the wrong science even worse.

- 2. Secondly, the most successful countries implemented a comprehensive and rigorous “test, trace and isolate system quickly” and from the outset.**

IT and mobile phone apps were part of those systems - in South Korea, a large part. In all successful countries the testing and tracing was devolved to localities with national support. Getting a test was made easy. Korea even applied continuous quality improvement techniques to enable speeding up of tests to increase throughput.

- 3. Thirdly, these countries imposed restrictions quickly.**

Vulnerable people were shielded (with particular attention to care homes), schools were closed, large gatherings banned, and borders either completely closed or closed to countries with known infection. Restrictions were enforced. Many countries put “stay at home” policies in place for lengthy periods, but again South Korea was the exception in that low risk groups could carry on with their lives while social distancing and wearing face masks. A solid “test, track and isolate” system gave South Korea the confidence to allow for this, and similar systems permitted the subsequent easing of restrictions in the other excellent countries.

**There were of course other measures taken, such as re-orientating health care systems to deal with COVID-19 demand.**

But the factors outlined above are the key pillars of the system response in successful countries. Together they engendered the other crucial element – trust.

The people in the successful countries all polled as having high trust in the response of their leaders.

Allowing large gatherings, poor test and track systems, and leaders not following their own advice, all eroded trust and therefore adherence to guidance in other countries.

**In those countries who haven’t done well, now facing inevitable spikes until a vaccine is available, it is still not too late to learn these lessons.**

2 - Tableau Public. COVID-19 Trend Tracker. Available from: [https://public.tableau.com/profile/jonas.nart#/vizhome/COVID19\\_15844962693420/COVID19-TrendTracker](https://public.tableau.com/profile/jonas.nart#/vizhome/COVID19_15844962693420/COVID19-TrendTracker).

3 - Institute of Healthcare Improvement. 2015. Like Magic? (“Every system is perfectly designed...”). Available from: <http://www.ihl.org/communities/blogs/origin-of-every-system-is-perfectly-designed-quote>.

## SHAPING THE FUTURE

# THE IMPORTANCE OF PUBLIC ENGAGEMENT

### IMELDA REDMOND CBE

Imelda Redmond is National Director of [Healthwatch England](#), the independent champion for people who use health and social care services. Imelda has 20 years' experience working in senior roles in the not-for-profit sector. She was previously CEO of the charity 4children, Director of Policy and Public Affairs at Marie Curie Cancer Care, and Chief Executive of Carers UK where she received a CBE for her services to disadvantaged people in 2009.

#### **Changing policy and practice in health and social care can take a very long time.**

But in recent months we've seen this doesn't have to be the case. Faced with an unprecedented crisis, services have adapted with remarkable speed.

#### **As the lockdown eases, we need to take stock.**

In the heat of the moment it's been hard for the public to have their say, to tell NHS and social care leaders whether the changes were working for them or not. As the country adjusts to a "new normal", and decides what we want to keep from the new ways of working, we need those in charge to hear from patients and care users who have experienced the changes first-hand.

After all, it is only through people's experiences that we can look beyond the facts and figures and really understand the impact of this pandemic.

#### **What people have been saying**

Right from the start of the crisis we knew that at Healthwatch we would have to roll up our sleeves and do our bit to help the response. Indeed, across the country we have seen our network shift focus, mobilising thousands of community volunteers to get help out to those who were shielding and others who needed it.

But whilst we are doing things slightly differently, we have continued our core work of gathering the views and experiences of people from a huge variety of communities.

#### **At national level we've already analysed over 7,500 of the stories shared with us.**

These cover not just people with COVID-19, but also those with a range of other conditions who have seen their treatment and support affected too.

#### **Many have spoken very highly of the dedication and empathy of the health and care staff involved in their treatment and ongoing care.**

Where praise has been forthcoming it's because staff and services were seen to be looking after people with dignity and respect despite the pressures.





**We have also heard consistent messages from across the country about NHS and local authorities needing to step up efforts around communication.**

This is both at community level, in terms of getting information and advice out to people, and on an individual level helping people understand what any changes might mean for their care.

In recent months we have also seen the NHS hail a number of achievements. The mass adoption of digital and telephone appointments in primary care is perhaps the best example: before the crisis 95% of appointments were done face-to-face despite huge change programmes over many years to introduce more digital ways of working.<sup>4</sup> Yet this has now flipped almost entirely, with 85% of consultations happening remotely.<sup>5</sup>

**However, there is an inherent danger in assuming that mass take up is the same as positive support from users.**

In many cases people have not had a choice about using this service. We know from previous research that people want the NHS to make better use of technology to make care more convenient, but are the recent changes working for them? Are there existing and new groups of patients who are being excluded from care as a result of the growing reliance on technology?

We have been listening intently to what patients have been telling us about these new services. We have also been carrying out specific research to find out about people's direct experiences. But this is an area where significant further engagement is needed before the NHS simply adopts digital approaches as the default option going forward.

**Making longer-term changes focused on the user.**

In these difficult times for all our public services, people's perspectives must be seen as a priceless contribution. They provide services and policy-makers with information they might not otherwise be able to access.

Precisely because Healthwatch has continued to engage and gather people's views in the midst of a crisis, we have a hugely valuable evidence base that we will be using to provide health and care services with vital insight.

**We do not and cannot speak for everyone.**

So I would urge health and care services to also take this opportunity, build on the public's willingness to help and encourage people to get involved in shaping the future.

4 -The Health Foundation. May 2020. How might COVID-19 have affected people's ability to see their GP? Available from: <https://www.health.org.uk/news-and-comment/charts-and-infographics/how-might-COVID-19-have-affected-peoples-ability-to-see-GP>

5 - Castle-Clarke, Sophie. What will new technology mean for the NHS and its patients?. The Health Foundation. Available from: <https://www.health.org.uk/sites/default/files/NHS-70-What-will-new-technology-mean-for-the-NHS.pdf>.



# ACHIEVING THE SEEMINGLY IMPOSSIBLE

## LESSONS FROM THE SEACOLE CENTRE

### DR KATIE LANSDPELL

Katie Lansdell is an Associate Director at PPL with nearly 20 years of experience in the consulting industry, most of which has been spent working on integrated care. As the COVID-19 lockdown started, she was asked to transition the programme she was working into support to develop a new community hospital in response to COVID-19: the NHS Seacole Centre in Surrey.

#### **When I first began learning about project and programme management, we were asked a question – how long does it take to build a house?**

We thought about it for a while and came up with a range of answers from a week to several years depending on how complex the design was and whether you counted "building" as including a design phase or not. Then we were shown a time-lapse video of a house being built from a standing start in one day! There were swarms of people running over the site to a carefully choreographed plan. My recent experience with clients during the COVID-19 pandemic has made me think of this again.

#### **Time and time again I've heard stories of how we have been able to achieve things that were seen as impossible, whether a mass shift to online consultations or building new hospitals from scratch.**

At PPL, I've been involved in supporting the development of the NHS Seacole Centre at Headley Court, a community bedded rehabilitation and step-down facility, developed from a decommissioned military rehab centre. The Centre was opened by Matt Hancock, Secretary of State for Health on 4<sup>th</sup> May 2020, just 35 days after the need for it was confirmed.<sup>6</sup>

#### **As the COVID-19 outbreak started, health and care systems across the country began to look at their capacity to cope with a rising demand for specific types of care.**

Initially, a series of Nightingale hospitals were developed for people requiring critical care. Meanwhile, in Surrey, it emerged that there was a need for more bedded step-down care and rehabilitation.

Capacity and demand modelling showed that around 300 beds would be required from April to receive people who no longer needed acute care but could not yet go home. A range of options were explored, and a former military rehabilitation centre was identified as an ideal location to create a new community super-hospital for Surrey and surrounding areas.

#### **We were engaged to support the development of the clinical model and for performance monitoring, just as the UK lockdown began.**

We quickly adopted virtual methods of communication and collaboration to develop this at a rapid pace, drawing in clinical expertise in geriatric care, general practice, therapy and social care to develop a model based on accepting people that were still recovering from COVID-19 and had quite high needs.

#### **Creating a new hospital from a standing start is a challenging process that requires thinking through all the support services that are often taken for granted on an established hospital site.**

This includes everything from diagnostics, pharmacy, oxygen supply, mortuary, chaplaincy, transport, to how visitors are directed and supported – all of which need to be considered and set up.

#### **In the midst of any crisis, things change.**

As the combined teams were working through the above, the modelling work was updated and, due to the success of public health measures to keep the COVID-19 outbreak in check, the need for these beds changed in nature and time.

In addition, the crisis in care homes meant that a real worry was about an increased need for step up care from care homes. This required the clinical model to be revised and those changes quickly agreed by all Integrated Care Partnerships across Surrey.

<sup>6</sup> -NHS News, available at <https://www.england.nhs.uk/2020/05/temporary-nhs-community-hospital-in-surrey-named-after-mary-seacole/>.

**A business case that secured the necessary funds was written and approved in just a few days.**

I believe this was proof in action of our firm belief that it is not the document that holds the value, but the quality of the conversations which have gone into making it. We had had countless conversations with a range of teams working on this over the preceding weeks, which made the development of the business case straightforward.

**Since the Centre opened, our involvement has moved into supporting the development of a system-wide Performance Board, with a comprehensive integrated dashboard of information to support it.**

This board monitors usage patterns and plans future improvements. It has been a forum for gathering information across the system about the ongoing and changing need for the facility, as well as learning about what is working well in terms of treatment and rehabilitation. It has been genuinely amazing to see the progress made in such a short time and a testament to the hard work and dedication of our clients.

**We have all been through some dark times recently, but there are some real positives which we can take forward. One which I will keep with me is never giving up, even when things look impossible.**



# OVERCOMING BARRIERS

## THE RISE OF THE MACHINES

### DAVID NEWELL

David Newell is Head of Healthcare at Gemserv. David has a 30-year career focused in delivering digital transformation of healthcare. David started his career as an NHS CIO and has led a range of healthcare software vendors and consulting businesses.

#### **My career for the last 30 years has been focused on delivering technology-enabled change to the health and life sciences sector.**

Over that time the label has changed a few times: "informatics", "IT" and more recently "digital transformation". But two things have remained constant. The challenge has always been to change the way we work by adopting new technologies. And that challenge has always been surprisingly difficult to achieve.

#### **Technology-enabled change in the health service is a complex challenge.**

Indeed, change in any environment with such a complex set of interrelationships, stakeholder groups and conflicting priorities would be a challenge. But it is safe to say that digital transformation in healthcare has fallen behind many other parts of society.

The recent National Audit Office report on Digital Transformation<sup>7</sup> in the NHS concluded that while the main bodies plans for digital transformation are "ambitious", the track record in the NHS has been "poor".

#### **Something different began in March 2020.**

In March our teams were working hard with a number of clients. In particular, our work with the Isle of Man Transformation programme was gathering pace. We were actively involved in the delivery of Sir Jonathan Michael's 26 recommendations from his earlier Independent Health and Social Care Review.<sup>8</sup> I personally was commuting to the island on a weekly basis, leading service reviews and supporting the digital change agenda. And by the end of the month the borders were closed.

#### **Given the difficulty of large-scale change, the prospects for programmes under these circumstances looked bleak.**

But over the first month we pivoted, changed our approach, re-planned and adopted new ways of working that were underpinned by technology. The world moved to video calls.

#### **It has not been easy, but it has been effective.**

In parallel, the same pivot has taken place across many aspects of our lives from work to education and entertainment. Our lives have changed in a very short space of time.

Areas of healthcare delivery that have long been discussed as targets for digital transformation have also rapidly changed, such as joint, remote working using Microsoft Teams for Multi-Disciplinary Teams (MDTs) and online consultations in primary care and outpatients.

#### **These technologies were deployed in days, not the months or years which had been the norm prior to COVID-19.**

These rapid deployments are not without their own challenges. I am sure that there will be a degree of remedial activity required. Information governance and data protection in particular will need some attention as the debate around privacy and contact tracing has impacted adoption. I am also sure that cyber-security will be an ongoing issue to address, as criminals exploit what they perceive as the COVID-19 "distraction" to attack the NHS.

#### **Out of the challenge of COVID-19 has nonetheless come one fundamental change.**

We have proved that rapid technology-enabled change in healthcare is not only possible, but it works. In many areas of service, "digital first" will become the norm. The term "outpatients" will take on a new meaning. As we help our health service clients through service re-start and recovery, the role of technology in service redesign is critical. In 30 years, I have never seen "normal" change as quickly.

#### **But I also believe we can use technology to jump pass the "new normal" to a "better normal": where digital transformation is that norm.**

7 -National Audit Office. Digital Transformation in the NHS. May 2020. Available from: <https://www.nao.org.uk/report/the-use-of-digital-technology-in-the-nhs/>.

8 -Michael, Jonathan. Independent review of the Isle of Man health and social Care system. April 2019. Available from: <https://www.gov.im/media/1365879/independent-health-and-social-care-review-final-report.pdf>.

# POWER AND THE PANDEMIC

## THE LIMITS OF COMMAND AND CONTROL

### PROFESSOR PAUL CORRIGAN CBE

Paul Corrigan was previously Director of Strategy and Commissioning of NHS London Strategic Health Authority, a Special Advisor on Health to the UK Government, and a non-executive director of the Care Quality Commission. He continues to advise leaders both in the NHS and internationally and is one of the UK's leading opinion formers on healthcare.

#### **Many of us have lately spent our afternoons watching press conferences in Number 10, waiting to hear what was going to happen to us.**

Alongside pronouncements from a powerful central state, from February 2020 we saw the NHS nationally mobilising ICU beds, acquiring ventilators and building new facilities to meet the expected demand for acute care beds.

The Prime Minister promised a "world beating" test, track and trace system, run from Whitehall, that would decide which locations needed to be locked down after speedy central diagnosis.

#### **This all looked to be a recognition that, in a time of crisis, power comes from the centre in the form of command and control.**

And yet, so much of this only worked in practice because of the actions taken by the public and at a locality level. And so much didn't work because this was not understood.

#### **It was the public that were expected to decide whether their coughs and fevers were hay fever or possibly COVID-19.**

They could ring 111, but they were then asked for some form of self-testing for temperature and other symptoms. The public were also the people who were required to significantly change their behaviour. Most polls show high public agreement with lockdown as a way of staying safe.

#### **In fact, many people were changing their behaviours before the government told them to.**

An unintended consequence of central directions around boosting NHS critical care capacity was the transfer of significant numbers of untested, vulnerable patients into local residential accommodation, effectively spreading the virus into localities.

Conversely, it was the staff of thousands of individual care homes who sacrificed and fought the disease for weeks before national testing regimes caught up with what was needed.

#### **On "test, track and trace", the national system has so far failed to provide local public health professionals with up-to-date and useful information about outbreaks in their localities.**

As we saw in Leicester, a national government can order a local lockdown, but it takes local government to make it work.

#### **The real lessons of the lockdown are that, in the modern world, the centre encounters limitations when solving problems across the country.**

You need proactive activity from millions of engaged people, rather than obedience from a cowed population. If you want to appeal to civic pride for people to self-quarantine and not infect their neighbours, then you need civic institutions to mobilise that pride.

#### **Modern society, with its digital relationships, is a much more decentred experience of power.**

Many of the issues in the response to COVID-19 so far could have been and can be avoided, if central governments are able to recognise this reality.

**PART 2**

# **THE ROLE OF PEOPLE POWER**

## REFLECTIONS ON THE CRISIS RETURNING TO THE SERVICE

### WILLIAM ROBERTS

William Roberts is Head of Health and Social Care at [Innovation Unit](#), a social enterprise that grows new solutions to complex social challenges. Previously, he was a member of the senior leadership team at NHS England in the New Care Models and System Transformation Group. William has a clinical background in infectious and tropical diseases. When the pandemic hit, he chose to step again into his frontline role, to support the pandemic response.

#### **When COVID-19 started to peak in March I decided to go back into the NHS to provide support where I could.**

In part this was a deeply personal choice. I spent over twenty years working in the NHS prior to joining Innovation Unit and my clinical background is in infectious and tropical diseases. Like the thousands of people who signed up to help out, from local mutual aid groups to staff returning to their profession, I simply couldn't not contribute, especially after listening to the stories I heard from my wife, coming home from 13-hour shifts in ICU.

#### **I made a call on the Friday and on the Monday I was in my local system.**

I've done everything from modelling capacity and demand to brokering relationships between key partners and moving beds around a hospital. It has been a bit of a whirlwind. I am in awe of the people I have worked with over the last three months, from health and care workers, to the charities, the estates and facilities staff and members of the public.

Now, three months on, I have a few reflections.

#### **COVID-19 is on a scale none of us has ever experienced, so we are all learning.**

I've nursed most infectious and tropical diseases and have led large public health initiatives. I worked through Swine Flu and SARS. But I've seen nothing like this and friends say the same.

Knowing what you do know, where you add value and that we are all learning is essential if we are going to really make a difference. Once I accepted I was learning, it made the doing a lot easier for me and others.

#### **It's a marathon, not a sprint.**

Everyone says this, and then proceeds to sprint as hard as they can. It's hard not to and at times I felt myself caught up in this. But I also saw hardworking and passionate colleagues exhausted and struggling.

With a vaccine still months, maybe even years away, we are going to have to find ways to recharge and refresh and slow down our thinking to ensure we can cope with the next period.

People are exhausted and we still have a long way to go. Having run a couple of marathons, it's all about the training and pacing. Ensuring we support staff to take leave, not seeing everything as urgent, and clearing out unnecessary bureaucracy are going to be key to sustaining our efforts.

#### **Rapid prototyping, freedom to try, and understanding not everything will work.**

I've led and consulted on major change programmes for the last decade. In that time, I've never seen the appetite for trying new things that I have experienced over the past three months. Seeing leaders enable people to try new things, to prototype and accept that not everything will succeed, has been revelatory. Seeing staff working with the permission to test and learn has been a joy.

Frontline staff and managers working towards a common goal with the freedom to act has meant that things that would have taken years to achieve happened almost overnight. Watching leaders be brave and give their teams this explicit permission has been a real privilege, and I hope this is something that will be sustained post COVID-19.

#### **Not everyone has experienced the last three months in the same way.**

Whilst we have seen unprecedented change over these last few months, a range of services have rightly been put on hold. For those that haven't been part of the whirlwind change, and for the service users whose care and support has not been available, we need to move from crisis response to effective recovery and we need to involve our staff and users in that recovery.

The long-term impacts of COVID-19 will be on the wider population health. The last period acts as a sharp reminder that, whilst we have all experienced this, in reality it is the poorest and most vulnerable who have been disproportionately impacted by COVID-19. Our greatest challenge remains inequality, both structural and personal.

**Change has happened, and relationships have been built, but it needs to be embedded.**

“We’ve made massive strides, and we can’t go back”. This is a thing I’ve heard time and time again over the last three months. In reality, this is easy to say but much harder to do. Like any good relationship, it’s going to take time and effort to make it work.

This means that the effort we made to get to know each other has to be more than a crisis response. We will need to find ways to continue bringing people together to work effectively.

**Importantly, this will mean bringing service users to the heart of those relationships so that what we develop for the next phase responds effectively to their needs, rather than just the immediate crisis.**



# MENTAL HEALTHCARE IN A PANDEMIC

## POLICY AND PRACTICE

### REBECCA BURGESS-DAWSON

Rebecca Burgess-Dawson is a National Clinical Lead (Mental Health) at Health Education England. Rebecca is a mental health nurse by background and during the pandemic she chose to be released from her duties at Health Education England in order to support services on the frontline.

#### **My name's Becky and I'm a mental health nurse.**

I'm also one of the three mental health clinicians working within the mental health programme, alongside a clinical psychologist and a consultant psychiatrist at [Health Education England](#), an Arm's Length Body working with other parts of the NHS to ensure that people have the right skills, values and behaviours to create a workforce fit for today and ready for tomorrow.

I work as an integral member of the mental [programme](#) team looking at both the way mental healthcare can now and could in the future be delivered, and the best ways of training and educating all the workforce to be better informed about mental healthcare.

#### **As a healthcare educator, I've always believed that there are two ways of being proficient in clinical practice to deliver safe and effective patient care and to support others to do so: competency and currency.**

I received brilliant education and training to be a mental health nurse from some outstanding mentors and was proud to pass my exams and qualify; but that was a quarter of a century ago! So, I became competent, but if I wasn't able to maintain at least an occasional role directly in practice, can I remain current?

#### **This struck me as one of the biggest initial challenges when COVID-19 began to issue its challenge to the NHS.**

As a respiratory illness predominantly, that portion of the workforce with skills in intensive care and environments where patients are ventilated were immediately required.

Those with skills from previous roles had to be "refreshed" with rapid yet robust training programmes, and new staff had to have their skills expanded and consolidated. Anyone redeployed into these roles needed their regular duties backfilled by someone else to ensure that services continued to function.

#### **Once again, the will of the healthcare workforce amazed me.**

[Thousands of student nurses](#) opted to join NHS frontline staff in its response to the COVID-19 pandemic by undertaking a paid placement directly related to helping in the pandemic response, and many more previous NHS staff volunteered to come back and add their efforts.

Health Education England responded with their [e-Learning for Healthcare hub](#) packed with learning content, that was made free to access anywhere in the world and without login requirements. Even now as infection rates thankfully fall, interest in an [NHS career](#) amongst the public continues to rise.

#### **This gives me great hope for a bright future for the NHS's workforce in the first instance.**

However, as a mental health professional, in some ways I believe there is a whole fresh challenge yet to come, one which will have greater long term demands on the health of the nation.

#### **There is hardly a place on earth where people have not been exposed to psychological trauma as a result of COVID-19 transmission.**

Some have lost loved ones during physical distancing that has made the loss even more traumatic. Some people have experienced anxiety and fear like never before. Loneliness and isolation, and a reluctance to seek help from a compromised healthcare system have in many cases compounded the problem. Those with pre-existing mental health issues may have not been able to access or have not yet come forward for treatment.

#### **I have been extremely proud that Health Education England allowed me to be released to undertake an opportunity to be on the "frontline" during the pandemic.**

However, in an apparently counterintuitive response, several services that I initially approached with that offer said that a reduction in referrals and interventions coupled with my potential transmission risk meant that they would prefer I did not assist them!



Over the last few weeks, as physical distancing requirements have eased somewhat and the transition is being made to recover "normal" functioning, I have been asked on a daily, and sometimes hourly basis if I can provide assistance to my local mental health services.

**It's been an absolute honour to help whenever I can.**

Observing and experiencing emergency mental healthcare once more has reinforced to me that the flexibility in delivering

- **directly to the workforce the education and training that they need right now**
- **in a place accessible to them**
- **and in a format they can combine with busy clinical practice**

has to be one of the key learning outcomes for us as policy makers and implementers in the future.



# HUMANITY AND THE PANDEMIC

## HELPING EACH OTHER THROUGH THE CRISIS

### PATRICK HANRAHAN

Paddy Hanrahan is Strategy and Innovation Director at [Helpforce](#), a Community Interest Company founded to develop volunteering in the NHS. He was instrumental in taking Helpforce from an idea to a national organisation, having been involved in establishing the Centre for Ageing Better. Paddy was previously a Managing Director at Accenture, where he worked for 13 years, largely with NHS clients.

#### **During the onset of the COVID-19 pandemic, there were times I felt an underlying dread.**

Could this be the end of the world? I can reflect now that those moments were fleeting. What we can say is that it has been a wake-up call for humanity.

Absorbing too much news and too many polarised views on social media can make it hard to keep faith in homo sapiens but, when the pandemic struck, we were reminded that we are fundamentally social animals.

#### **Within days, entire communities had mobilised.**

Near where I live in London, there were WhatsApp groups formed at a family, street, district and borough level, with a surge of volunteers willing to help coordinate and undertake tasks for the greater good. Despite the fear of this new unknown virus, there seemed no limit to the number of people willing to help out neighbours and bring food and supplies to those most vulnerable and scared. It was uplifting to be part of, and a source of reassurance during uncertain times.

#### **Reflecting back, I realise that this response was amazing, but there was often not a lot to do.**

I was a member of four "informal" mutual aid groups and received just one task. At my local NHS hospital, I put myself forward for three different roles created specifically for COVID-19 but was never called upon. I was one of 750,000<sup>9</sup> to sign up to the NHS Responders scheme (which as an aside I welcome as an important piece of national volunteering infrastructure). It was six weeks before I was allocated a task.

#### **So, what can we learn?**

Most people want to help, and it makes us feel more secure, more worthy, more human. However, do we have a problem with actually asking for help in the first place? Why was there not more demand? Or was the demand there,

but people were unwilling to show that they needed help? Or were the groups and initiatives that were formed unable to find the demand, failing to recognise that there were groups already in place (such as local charities) that were already connected? Within the NHS there is a similar problem.

#### **There is plenty of need - demand has never been greater, even before COVID-19 struck.**

How do we convert more of that need into opportunities for volunteers? Into opportunities to contribute in a meaningful and impactful way? Into opportunities to help those people most in need, to support our heroic NHS staff, and to benefit communities and health and care services while making the best use of the skills and time we can offer?

#### **Helpforce was created to assist health and care organisations with this challenge.**

Our mission is to accelerate the growth of volunteering opportunities, by proving the impact that volunteers have on people (on staff, patients, communities, and volunteers themselves) and services (in terms of productivity and efficiency).

#### **The evidence shows that there is a case for far greater involvement of volunteers in our future health and care.**

And when pandemics and other disasters strike again, we must better utilise the gift of skills and time on offer.

9 -NHSEI. April 2020. NHS army of volunteers to start protecting vulnerable people from coronavirus in England. Available from: <https://www.england.nhs.uk/2020/04/nhs-volunteer-army-now-ready-to-support-even-more-people/>.

## VOLUNTEERING IN THE PANDEMIC

### SOURCING OUTSIDE THE BOX

#### LAURA WALSH

Laura Walsh is HR Manager and Consultant at PPL. During the height of the pandemic she led PPL's operations team volunteering with Surrey County Council, sourcing donations and support as part of the council's emergency response.

**At the height of the pandemic, parts of PPL's operations team were re-deployed to volunteer in support of Surrey County Council, sourcing donations and supplies to protect key workers and improve the lives of NHS staff, patients and vulnerable residents in Surrey.**

Our team worked closely with a dedicated and driven team of public servants in Surrey to understand requirements as they developed and to do what we could to help. Putting in over 150 volunteering hours, over a 7-week period, this included contacting 180 businesses nationwide and working with them to secure donations of personal protective equipment (PPE), food boxes, fabric for medical scrubs, technology for care homes and hygiene products for those shielding.

**The team were tasked with thinking outside of usual sourcing routes.**

This meant appealing to a variety of businesses across the country; and alongside sourcing corporate donations, the most interesting research ended up being around identifying businesses that had or could re-purpose their facilities to produce PPE and other critical supplies.

The biggest successes included finding gin distilleries now producing hand sanitiser, and a building insulation company turning out material suitable for protective medical scrubs.

**The response from national and local organisations was incredible and heartfelt.**

From significant discounts on essential purchases to many one-off donations, including a 75-meter roll of scrub fabric which helped produce over 20 nurse scrubs for the NHS and a 120-meter roll of fabric for Surrey's Handmade for Heroes Campaign, we have found a ready willingness to help from across businesses and communities.

**The COVID-19 crisis has showed us the importance of understanding what we want to achieve as individuals and as organisations.**

Only then can we begin to decide what to do first, in order to reach that outcome.



(Scrubs made from the fabric donated by Toray Textiles Europe Ltd)

# MAKING A DIFFERENCE

## GIVING VOICE TO THE HARDEST HIT

### CHARLOTTE AUGST

Charlotte Augst is the Chief Executive of [National Voices](#), the coalition of charities that stands for people being in control of their health and care. Prior to joining National Voices in March 2019, Charlotte led the work of the Richmond Group for five years, developing strategy, facilitating discussions and representing the Group externally. During the pandemic, she has led National Voices to advocate for the parts of society most impacted by COVID-19.

#### **Being asked to write this short blog about our work since COVID-19 was an opportunity for us to take stock.**

So, how did we, as very small organisation with a very new team, make decisions to find our way through this crisis?

#### **It is important to realise that the people whom we feel we were put on this planet to serve and work with have been hardest hit by this pandemic.**

People with long-term conditions are most likely to have had severe complications from a COVID-19 infection and they are also most likely to die from the disease.<sup>10</sup> Roughly one in four people who died of COVID-19 had dementia. Roughly one in four had diabetes.<sup>11</sup>

#### **However, perhaps even more importantly for our work, we must remember millions of people had substantial health and care needs before this crisis started, and they still have these needs.**

But these needs have very often not been met. Across the country tests, treatments, home visits, visits from family members, and support visits for people with special needs have been cancelled. This has also led to pain, suffering, hardship, and, as we now know, to deaths.

#### **What could we, a small membership organisation, possibly do to make any of this better?**

A lot, as it turned out. We focused on two core activities which have shaped most of our work over the last few months:

#### **1. Taking key themes from our member organisations to decision-makers.**

What are the key themes in the challenges our members are hearing about

and dealing with? They include food security, isolation, mental ill health, shielding, the digital divide, inequalities and more. We took these issues to decision-makers, particularly to help our members who don't have large policy or public affairs teams.

#### **2. Creating a platform for people with health and care needs to say what they want and need.**

What are people with health and care needs saying about what they want and need? To find out, we created [Our Covid Voices](#), where anyone with ongoing health and care needs can talk about their experience of health and illness during this period. We have taken what we have learned from the insights they've shared to the Health and Social Care Select Committee, the Care Quality Commission, the Department of Health and Social Care, NHS England, and expert audiences through well-received comment pieces in HSJ and the BMJ.

#### **It is hard to claim you are having a clearly-defined impact in the world of influencing, particularly as the normal rules don't always apply during a crisis.**

But we have a sense that we have made ourselves, the work of our members, and maybe most importantly, the experiences of often very vulnerable people, more visible and audible during this very noisy and fast-moving period.

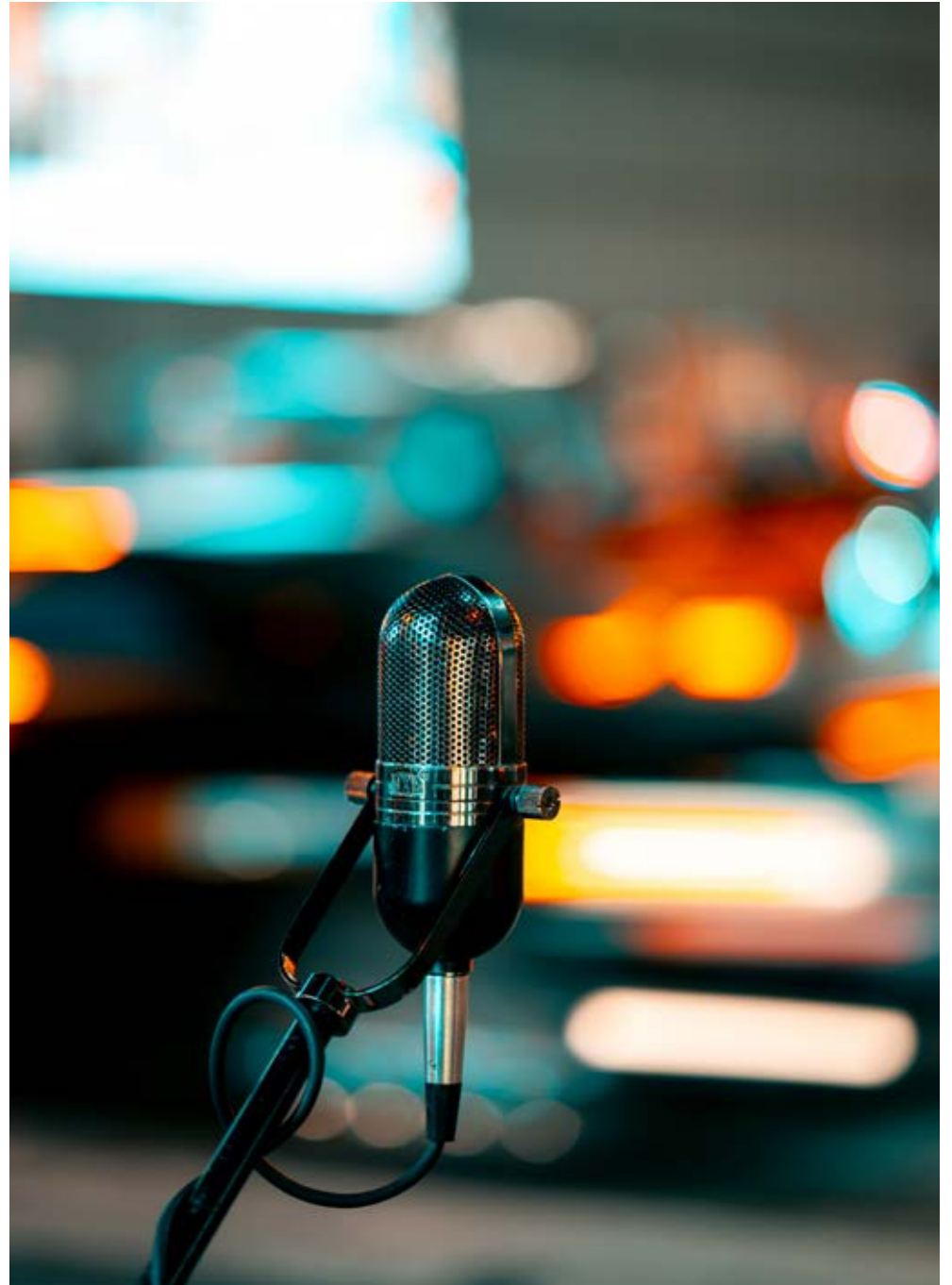
We have received some great feedback from people who are shielding, from members, and from decision-makers that this contribution has felt useful and timely to them. We feel this is not bad for a small and under-resourced organisation such as ours.

10 -NHS, People at higher risk from Coronavirus (COVID-19). Available at: <https://www.nhs.uk/conditions/coronavirus-COVID-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/>.

11 -Office of National Statistics. Coronavirus (COVID-19) roundup. July 2020. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronavirus-COVID19roundup/2020-03-26#causeofdeath>.

**We have worked incredibly hard (harder than we can sustain in the long run) and so our next task is to consolidate, to take stock and to slow down.**

So many people have experienced such hardships during these last three months. It feels good to know that we have at least kept a record of these experiences and enabled them to be heard by those people who are designing our country's response to this crisis, and that we have done this with authenticity and a sense of moral urgency.



# WORKPLACES IN THE PANDEMIC

## THE VALUE OF KINDNESS

### IYONI RANASINGHE

Iyoni Ranasinghe is a Senior Consultant at PPL. Iyoni joined PPL after nine years in the NHS as a Mental Health Nurse. She has since worked on a range of national and place-based transformation and quality improvement programmes. During lockdown, she was part of our Mental Health First Aid Team and responsible for developing a number of wellbeing resources

#### **As the coronavirus pandemic rapidly swept across the world, it brought with it considerable degrees of fear, worry and concern.**

This was true both among specific groups such as older adults, care providers and people with underlying health conditions, and the population at large. In public mental health terms, the main psychological impact to date was (and still is) elevated rates of stress and anxiety. New measures and the knock-on impacts on our day-to-day lives through lockdown have meant that levels of loneliness, depression and harmful behaviour have risen.<sup>12</sup>

#### **We realised it was more important than ever for each of us to consider how we could proactively look after our own emotional wellbeing.**

We found it helpful to recognise that whilst the pandemic is global, everyone experiences it differently. People are facing different challenges in different circumstances and no one's reaction will be quite the same as anyone else's.

#### **There is no "right way" to be in the moment and no single solution for everyone.**

Understanding this allowed us as a team to support our colleagues' mental health insofar as we could in these unprecedented circumstances. Practical steps included:

- Weekly surveys of all employees.
- Creating a staff wellbeing guide.
- Pairing colleagues for weekly "buddy" catchups.
- Twice daily online "coffee breaks".
- Mental Health First Aid Team volunteers providing direct support to individuals.
- Providing continuity through moving regular team touchpoints online.

#### **We also curated a selection of resources and tips to help people adjust to the "new normal".**

These practical tips ranged from encouraging people to reach out to others, setting boundaries around the working day, and dressing for the life you want, not the life you have!

#### **As lockdown progressed, employees' engagement with these various support mechanisms understandably varied.**

Like everyone else, we have experienced highs and lows as we adapted to government advice. We also recognised that when colleagues did not feel like talking to anyone at all, that was often when they should. With the evolving situation, we felt as an organisation it was important to keep the changes in place whilst flexing them to better suit everyone's needs, e.g. reducing daily buddy catch ups to weekly after the first few weeks. This ensured employees felt adequately supported and able to engage with the support mechanisms when they felt able to, whilst personally navigating uncertain times.

#### **We took a stocktake part-way through lockdown in May 2020, capturing experiences and learning.**

We asked what achievement people were most proud of professionally and personally, as well as what they wished they had known from the start of lockdown. Unsurprisingly, most people mentioned they would have preferred to have known how long lockdown was going to last to prepare better mentally.

#### **Employees were proud of being able to continue to produce high quality pieces of work and adapt to the new (albeit tough) way of working.**

We also recognised a range of responses from people welcoming the slower pace of life during lockdown, to others feeling proud to be able to keep their head above water!

12 -Laake, J.P., Majeed, N. March, 2020. Rapid response: COVID-19: a physical and mental health epidemic. The British Medical Journal. Available from: <https://www.bmj.com/content/368/bmj.m764/rr>.

**Overall, colleagues responded that while there had been ups and downs, they were proud of keeping going and continuing to support each other and their clients.**

Self-care, support networks and generally connecting with others were all seen as being vital to people's resilience within the organisation, and these helped them through this difficult period. Taking time out away from laptops and phones, and the tiredness that can come along with them, has helped people with their mental well-being.

**Whilst organisational support mechanisms have helped by providing some form of continuity in people's work lives, what we have taken away from this difficult experience is, ultimately, that we should all be kinder to ourselves.**



**PART 3**

**BUILDING BACK BETTER**



# TAKING THE OPPORTUNITY TO BUILD BACK AND TRANSFORM

## LAURA CHURCHILL

Laura Churchill is the Director of the London NHS Sustainability & Transformation Partnership Network. Previously, she was Executive Director of NEL Healthcare Consulting. Most recently she has led the London Improvement and Transformation Architecture programme, which aimed to redesign how improvement and transformation activities are delivered in the capital.

### **Last year I wrote a blog about resistance to change and the steps we can take to make transformation less painful.**

I was unapologetic about the scale of ambition behind the programme I was leading, recognising that the whole health and care landscape is shifting in order to create integrated care systems across the country. As a result, it was unfathomable that any organisation that considered itself to be part of those systems could stay static and still be relevant. I reflected that traditional industries everywhere are experiencing change, driven by progress in digital technology.

### **Constant change was about the only thing that could be expected. Economists call it VUCA: Volatile, Uncertain, Complex, Ambiguous.**

Nothing, however, could have prepared me for the impact of the COVID-19 pandemic. If we thought we were navigating a VUCA world a year ago, we were, and continue to be, pushed to new heights now.

My role sits within the NHS in London. I work for the five Integrated Care Systems / Sustainability Transformation Partnerships on regional priorities that they choose to drive forward together. I look around me and very few of my colleagues are doing the same jobs as they were just four short months ago. I've had some colleagues approach me in despair and dismay, and others in exhilaration and excitement. Many of us are wrestling with the impact of COVID-19 not just on our professional lives, but on our personal lives too.

### **We have oscillated between a deep-rooted sense of pride in the system we serve, and the uncertainty of what means for our own, personal place within a system that is unrecognisable from the one we knew.**

I found myself wondering if the suggestions I made last summer, about making change less painful, could still be applied in this new world. Here are my musings.

#### **1. Transformation is not crisis management.**

Crisis management is what happens when we wait too long to do something about an issue or where we need short term fixes.

Throughout the COVID-19 crisis response I have observed, and felt, the energy of a crisis. I admit that it was exhilarating and even rewarding at times.

However, over an extended period, it is exhausting and stressful. I'm now witnessing the slump of the shoulders, and blood-shot eyes that are looking at the long road ahead to restart services whilst considering the prospect of a second wave and localised outbreaks.

We are tired. After months of long-hours, little or no time off, and the constant rush of fear and adrenaline, there is little left in the tank. As we recover, we need true transformation, not crisis management. We must be driven by strategy and longevity. We need to enact our recovery with calmness and consideration, albeit at pace.

#### **2. We cannot transform something with the sole purpose of hitting a target.**

In an integrated environment, targets relating to single parts of the system (geographies, organisations or sectors) will only create barriers and channel programmes into work that is siloed and divisive.

The COVID-19 crisis has brought into sharp focus how dependent we are on each other across the health and care system. Never have we ever had such stark examples of the connections between hospitals and the community, or between health and social care.

This week, we are starting to see headlines again about reintroducing performance management across NHS trusts. I understand the reasons, but grounding our recovery from COVID-19 in hitting targets will serve only to undo the partnerships we have forged over the last four months. Instead, the transformation required must be about creating resilience and preparing our system, the whole system, to succeed in the long term. COVID-19 gave us a clarity of purpose that we have never seen before.

Regardless of where you worked we had one, shared, clear goal to save as many lives as possible as COVID-19 swept through our communities. Whilst "business as usual" has more facets and subtleties than this, we need to continue to inspire change through purpose and common ground, rooting our transformation in better outcomes for our patients and citizens.

**3. Transformation, by its very nature, creates conflict, and we should embrace and harness the energy and focus this brings.**

If you're transforming something and no-one cares enough to voice a different view, you're either not really transforming anything, or you're not engaging, in which case your change won't stick. Throughout the crisis, we let things go, keeping comments to ourselves where previously we would have wanted discussion and debate. It will not be like this as we transform through recovery. Money will be firmly back on the table, politicians will rightly expect appropriate consultation with the public before major reconfiguration is enacted, and we will, once again, have competing agendas, targets and masters.

In order to not lose the connections we have forged, or the appreciation we have gained for those outside of our immediate teams and organisations, we must embrace this opportunity to engage in heated conversation. This conflict will fuel innovation because it forces the consideration of divergent viewpoints and will drive improvement. It should, of course, be managed with respect, appreciation and an open mind, but it mustn't be avoided.

**The COVID-19 pandemic has been, for many of us, one the most challenging of times of our lives. We have seen devastating loss.**

But the actions we have taken in collaboration and partnership across our system, the incredible dedication of our staff and the commitment from Londoners themselves in following advice, meant that our capital was not overwhelmed. We have a great deal to be proud of, and the relationships we have forged and the learning we have had over the last four months are great gifts.

**We owe it to our system, and to our communities, not to revert to our old ways of working, but to build back, to transform, into something better than before.**



# SUPPORTING SYSTEM RECOVERY SUSTAINING POSITIVE CHANGES

## DR STEPHEN BOXFORD

Stephen Boxford is Head of Research at [Cordis Bright](#), which provides consultancy, advice and research aimed at improving public services. He has extensive experience working in multi-agency partnerships, involving Local Authorities, NHS and Voluntary & Community Sector organisations and is currently working on evaluation of the local care approach in Greater Manchester.

**At time of writing we have been in lockdown for more than 100 days. The health and social care system has experienced significant financial pressures for more than 10 years.**

In this context, we have witnessed professionals across the health and social care system continue to work hard and with dignity to look after and support the population through the COVID-19 pandemic.

Cordis Bright have been working with clients across health and social care to support them through the pandemic. This has meant using research and evaluation to support robust and improved decision-making, ensuring the right responses and that innovation, and approaches that have been shown to work, are continued as we move into recovery.

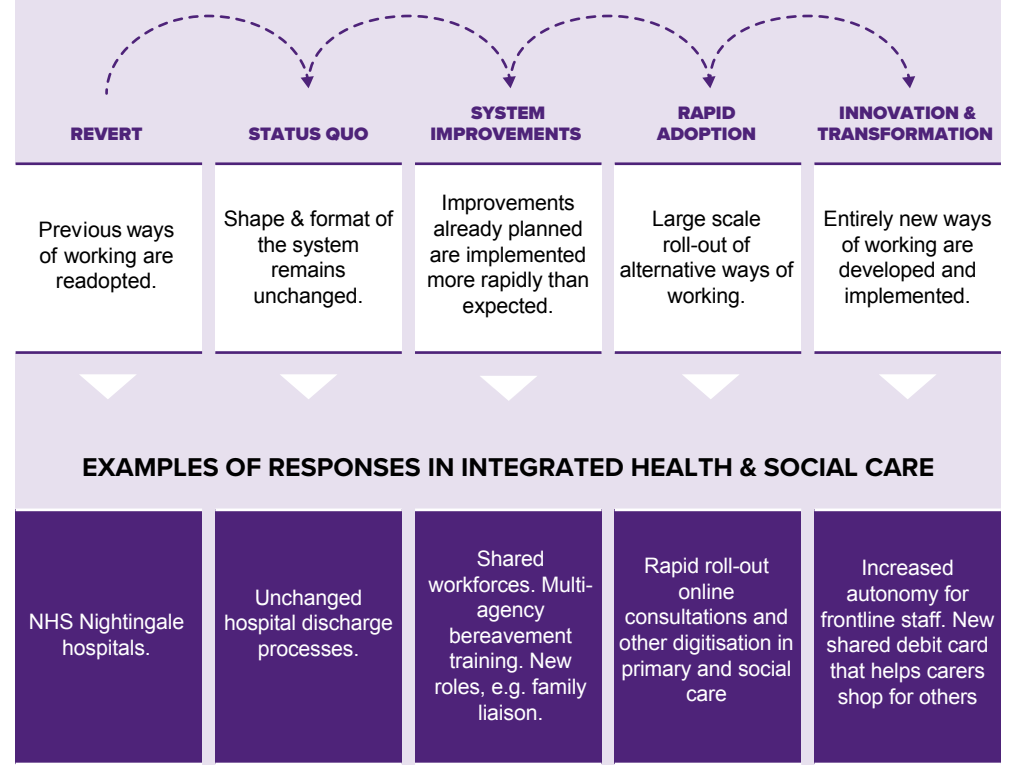
**In particular, we have been thinking about how systems work across health and social care and what the likely system responses will be as a result of the COVID-19 pandemic.**

We have identified five responses:

- Revert.
- Status quo.
- System improvements.
- Rapid adoption.
- Innovation and transformation.

## EXAMPLES OF SYSTEM RESPONSES IN INTEGRATED HEALTH & SOCIAL CARE

### FIVE SYSTEM RESPONSES TO THE COVID-19 PANDEMIC



**Linked to this, we have been using rapid evaluation to help clients understand how their local systems have responded and, most importantly, what the impact of these responses have been for local people.**

This has been used to help shape their immediate responses to the pandemic, as well as inform their thinking for the future. [Our approach](#) to real-time evaluation is multi-method and multi-stakeholder, creating a robust evidence base. It is quick to deploy, provides rapid learning, and focuses on outcomes for citizens. It is based on our track record of undertaking evaluations on complex, whole systems change involving multiple partners.

**The Making Every Adult Matter coalition (MEAM) recently commissioned us to conduct a rapid evaluation to explore the flexibilities adopted by services supporting people experiencing multiple disadvantage (predominantly homelessness, substance misuse, mental ill health and contact with the criminal justice system) during the COVID-19 pandemic.**

Positive developments had included more rapid responses to individual needs, new and / or more intensive types of support, greater strategic buy-in, better recognition of gaps in service provision, and improved partnership working and sense of shared purpose.

**The research concluded that, as we transition into the recovery phase, local areas and national government action is needed to sustain positive change. This includes:**

- **Reflecting closely on learning from the crisis period:** organisations, services and individuals have been adapting rapidly and the focus has been on delivery. Time, tools and processes will be needed so that local areas and national government can take stock of which new ways of working have had an impact and assess how to apply the learning for services supporting people facing multiple disadvantage.
- **Cross-sector leadership and planning to ensure positive changes can be maintained:** local areas and national government will need to identify the flexibilities that they wish to maintain and develop plans to ensure these can be funded and commissioned. The provision of suitable, permanent accommodation for all who need it will be a key part of this, but wider cross-sector flexibilities will also be important.
- **Ensuring the involvement of people with lived experience of multiple disadvantage:** responses to the pandemic have highlighted the importance – and power – of keeping people facing multiple disadvantage at the centre of decision-making and service design. Local areas and national government should seek to maintain this culture and manner of working when planning for the next stage of the response.

More about this research can be found [here](#).



# IMPROVING HEALTH AND CARE OUTCOMES

## COLLABORATING TO A BETTER NORMAL

### DAVID SEGAL

David Segal is a Manger at PPL. He leads PPL's Integration, Partnerships and Primary Care practice. David is an expert in system change and integration, specifically in the use of co-production to improve outcomes for people and communities. David has been supporting health and care systems in England to tackle COVID-19 while working towards a "better normal".

#### **The COVID-19 pandemic has had an almost unimaginable impact on society and our communities.**

It has placed incredible pressure on society's support structures including those that are provided by health and care systems. The long-term impact of the pandemic will not be clear for a significant period of time, and it is essential that system partners and communities come together now to build a vision for the future.

#### **Whatever happens, a return to normal is not possible for health and care systems.**

Doing what they did before will not be an option. The "new normal" has become a buzzword across media reports, referring mainly to the constraints that all of us will experience as part of the ongoing and lengthy COVID-19 recovery process.

#### **But alongside the devastating impact of COVID-19 on families, communities, our economy and our public services there are some new and positive realities.**

Whether it's the army of volunteers signing up nationally and locally, the mobilisation of communities to support those who are most vulnerable, or the extensive donations, COVID-19 has forced the creation of real and functioning community asset models, often operating in a way that could have only been aspirational a few months ago.

#### **As a volunteer food courier supporting vulnerable people in my area, I have visited community centres I had never been to before, cycled down roads I had not been down before, and met people I would not have met otherwise.**

This isn't because of a dramatic shift in my world view or my sense of social responsibility, but is simply due to knowing that there is something I can do to help, and a set of very dedicated people using simple communication tools to make that happen.

#### **Health and care organisations have also changed how they work to deal**

#### **with the colossal task of tackling the pandemic.**

In order to survive, organisations have had to come together, re-defining what system working and collaboration means, and in the process of collaboration crossing boundaries that had previously been impossible to break down.

My local authority colleagues describe the development of relationships with providers that are both supportive, pragmatic and honest (on both sides) and that would have been extremely unlikely in normal conditions. System processes have had to become adaptive, agile and innovative, finding new ways to tackle very new problems and old problems alike.

#### **Working with health and social care partners we have witnessed positive changes in system:**

- **Effective community engagement:** a public willingness to participate in their local community and an organic mobilisation of those people, moving beyond traditional models of volunteering.
- **A focus on local needs:** the ability to identify different needs and vulnerabilities in the local area and an active approach to shielding those people.
- **Genuine commitment to agile change:** the value of an experimental approach has been demonstrated in practice.
- **A shared goal:** the effectiveness of having one clear goal and mobilising multi-disciplinary working to achieve this.
- **Data sharing and better use of data:** especially in order to support early prevention.
- **Personalised approaches:** these challenge assumptions on how to support families e.g. providing flexibility in how families in hardship or crisis are supported.
- **Use of technology to support people more efficiently:** both in how we provide care but also how we communicate with each other.
- **Different modes of leadership:** adopting a more distributed model has been shown to be helpful, allowing creativity and innovation at all levels of an organisation.

**And yet the road ahead will not be easy.**

The "new normal" will be something that we will all have to endure, with the impact on some being much harder than on others. However, communities and local systems have shown that they can come together in ways that we did not think were possible to tackle these challenges.

**If we can capture both the learning and spirit of this moment, there is a genuine opportunity to move to a "better normal" delivering improved health and care outcomes in the future.**



## CO-DESIGNING THE WAY FORWARD

### RE-OPENING SHARED SPACES

#### JOSE ACUYO CESPEDES

Jose Acuyo Cespedes is a Senior Consultant at PPL with a background in pharmacy and public health. During lockdown, he was responsible for developing the "re-opening public spaces" framework, and has since been working with the public sector stakeholders to develop COVID-19 recovery plans.

**On 23rd March 2020, the British public received a very direct message from the Prime Minister: “From this evening I must give the British people a very simple instruction - you must stay at home”.<sup>13</sup>**

The timing of lockdown measures around the world will likely be debated for years, and the full impact is unlikely to be known for some time. However, in terms of the objectives of protecting the NHS and saving lives, there is broad consensus that the measures have flattened the curve of infection; and, despite many tragic losses, including amongst frontline workers and in care homes, these measures helped to safeguard both individuals and key public services.

**As a result, it became difficult for many of us to imagine feeling safe without social distancing.**

But social distancing comes at a cost, not just to our society and economy, but also to us as individuals and communities. In the same way as we adapted to lockdown, it became increasingly important to start thinking about how we moved into a new paradigm – where we still needed to protect the NHS, vital care services, and lives; but also to re-build broader public services, communities, and the life of the country.

**Much debate centred on how you can maintain full social distancing until an effective vaccine is found, and the honest answer is that we can't.**

There is no need for testing, tracking or tracing, expanded access to personal protective equipment etc. if we can all remain isolated from each other, but for many key workers, staying at home was already not an option. The schools that educate our children, the public transport systems upon which we rely, the places that act as a sanctuary for those in need, as well as those that entertain us and help us with our daily lives, very few of these could return to operation sustainably simply by imposing two-metre separations.

**For increasing numbers of workers, individuals, families and communities, the challenge involved staying safe, and protecting others, supported by other means.**

This is not to say that social distancing won't remain an important part of any pandemic response, and many measures which have been identified are supportive of, or supplemental to, continuing with social distancing where possible. However, if we cannot wait for a vaccine or cure, then this process showed that there were nonetheless things we can do to help ensure that any re-opening of public spaces, when it occurs, happens in a way which harnesses all the potential tools at our disposal.



<sup>13</sup> - Prime Minister's statement on Coronavirus (COVID-19): 23 March 2020. Available here: <https://www.gov.uk/government/speeches/pm-address-to-the-nation-on-coronavirus-23-march-2020>.

**The framework that resulted was co-developed using international best practice, national government guidance, and focussed thinking around potential issues and how to mitigate them.**

It covered eight core elements:

- 1. Physical space:** how spaces could be adapted to allow staff and service users to interact more safely, including areas such as hygiene, seating arrangements, ventilation, and signage.
- 2. Flow:** optimising the flow of staff and visitors to minimise “unnecessary” contact and maximise social distancing opportunities.
- 3. Equipment and supplies:** ensuring people have all the equipment they need to interact effectively and safely.
- 4. Technology:** exploring technological solutions to enable safe and effective working, for example reducing contact points, supplementing physical interactions or enhancing cleaning.
- 5. Travelling:** ensuring people are able to travel to and from the space in the safest way possible, including expanding facilities such as secure bike storage.
- 6. Engagement:** working with staff and visitors to understand and adapt to the rapidly evolving situation.
- 7. Meetings and events:** ensuring that larger meetings can take place safely, including tracking attendees and making spaces as COVID unfriendly as possible.
- 8. Service continuity:** developing and updating business continuity plans, and regularly updating risks relating to staff, service users and the organisation as a whole.

**Whilst there is a lot that was identified that could be done, challenges remain, including:**

- **Individual circumstances:** Whilst some people may be comfortable or even anxious to re-enter public spaces, everyone’s situation in relation to the pandemic has been understandably different, and many find themselves uncomfortable with the idea of going back into shared spaces.
- **Imperfect solutions:** The pandemic has evolved rapidly and is something that none of us have experienced before. The reality is that few solutions will be perfect first-time round.

**Co-design is a proven way of helping to bring people with a range of perspectives together to develop ideas that are stronger than anything we can produce alone.**

Critical to the success of these types of initiative has been giving people the (virtual) space to air new or existing concerns whilst simultaneously providing shared forums for the generation of new ideas.

**An iterative and flexible approach is key.**

The pandemic is a situation that affects each one of us and it is important that we are all involved in designing solutions. Having the humility and flexibility to recognise the need to change direction gives us the best chance of restoring spaces and services which are important to all of our health, wellbeing and our broader lives.





# SUSTAINABLE SAFETY

## PERSONAL PROTECTIVE EQUIPMENT IN THE COVID WORLD

### PEI-LING CHAY

Pei-Ling Chay is a Consultant at PPL. She has been helping to support the response to COVID-19, including working with the People Directorate at NHS England and Improvement Workforce Disability Equality Standard (WDES) Team to understand the experience of disabled staff through the pandemic; and separately led research into the use of PPE during the height of the pandemic.

#### **The COVID-19 pandemic saw significant challenges globally in ensuring an adequate supply of PPE to health and social care workers.**

The severe shortages of PPE and the continued pressure on supply chains meant there was a need to take a pragmatic approach, in particular for respiratory protective equipment (RPE). This meant that governments, researchers, manufacturers and practitioners had to explore the feasibility of reusing PPE in health and care settings, which is not normally considered practicable.

#### **At PPL, we supported clients to understand the emerging guidance on re-use produced by the World Health Organisation (WHO) during the pandemic**

Developments in PPE re-use guidance will ultimately have to be driven by further technical research, particularly into the feasibility of sanitising existing PPE ranges and rendering existing items fit for re-use.

Nevertheless, we identified a number of specific opportunities to optimise re-use in a time of shortages.

#### **1. Ensure that there is consistent understanding and monitoring of what PPE is re-usable and actually being re-used.**

This includes in care settings previously less accustomed to undertaking large-scale infection control, such as care homes and domiciliary care.

Public Health England and others did produce guidance, but there is further potential to work with wider partners (including the CQC, local authorities and care providers) to understand how this was applied and what further support or resources might be helpful. Central will be positioning appropriate re-use as a way of promoting safe practice, not an alternative to it.

#### **2. Ensuring that differences in type and manufacture of PPE are understood and leveraged across different care settings.**

Within categories of PPE, some are more robust or re-usable and some designed with disposal in mind. There is an opportunity to ensure the right types of PPE are being directed to the right settings. For example, PPE that can

be re-sanitised should be directed to those institutions which have the facilities to process items for re-use, freeing up supplies of equivalent disposable items for single use elsewhere.

#### **3. Implement sourcing strategies to source PPE that is more capable of being used safely multiple times.**

This includes working with procurement teams to ensure that, wherever possible, the ranges being procured are capable of being re-used.

#### **4. Work with manufacturers to design PPE that can be more easily re-used.**

For example, through the use of different materials, modular designs can allow for the replacement of specific components. This allows for re-use and can extend the number of times an item can be safely re-used.

#### **5. Ensure that processes and facilities are in place to support safe recycling of PPE after the end of its useful life.**

It is important that organisations investigate opportunities to establish local or centralised facilities to collect and re-process PPE that cannot be further sanitised or used by end users to reduce the impact of the increased waste that will be produced.

The research we conducted was initially aimed at supporting decision makers in health and social care settings. At the time of writing, the UK government has mandated face coverings for the general public on public transport and in shops and supermarkets.

#### **In the "new normal", PPE is now far more commonplace and extends beyond health and care settings, and this is likely to continue for some period of time.**

Organisations which would not have used PPE prior to the pandemic are now having to ensure an adequate supply and suitable training for their staff. As lockdown measures continue to be lifted worldwide, there is a pressing need to further develop the evidence base around safe, re-usable PPE, both to support contingency planning in the event of a second wave of COVID-19 and to operate sustainably in the world of the "new normal".



# TELEHEALTH

## WHAT'S NEXT FOR HOW WE ACCESS HEALTHCARE?

### CAIT BERRY

Caít Berry is a Senior Consultant at PPL. Prior to moving into consulting, Caít worked as an Occupational Therapist in the NHS, Irish and Singaporean healthcare systems. Caít has been working as part of the Helpforce Assist programme to support the North Central London STP in their recovery planning.

#### **As a result of the global pandemic, the telehealth revolution we have been promised for decades has finally arrived.**

The big questions now are: what does the future look like, and will it stick? This article explores what's next for digital health in our health and care sector.

#### **The pandemic forced changes that led to a significant increase in the use of telehealth in the NHS.**

An Ipsos MORI survey<sup>14</sup> revealed an 80% increase in the number of people that had used an online GP in the third week of March compared to the second week, demonstrating that the general public is willing to adopt telehealth, should it be made available.

Recent months saw a surge in not only the use of remote consultations (both online and by telephone), but also the electronic prescribing service and e-triaging. In the long term, continuing the use of these technologies could result in significant improvements to the speed at which services can see and treat patients.

#### **While we don't yet fully know what the "new normal" will look like, we know that to protect our healthcare system over the long-term and to continue to flatten the curve, we cannot go back to how things used to be.**

This means that out of necessity many of the new digital technologies currently being employed by the NHS will become more embedded over the coming months.

Traditionally, new technologies have been slow to achieve widespread adoption within the NHS. Analysis has shown that there are several barriers to the adoption of new technologies in the NHS, including financial, cultural and organisational barriers (such as a fragmented system). This has left little room to take advantage of new innovations. Sustaining the progress to date is vital

but there also needs to be room to evolve, particularly as attitudes towards telehealth have changed dramatically, presenting a new window of opportunity for the NHS.

#### **The first step in considering the "what next" is thinking about why many have quickly adapted to using telehealth in the first place.**

Online consultations have replaced visits to the GP and secondary care services for assessment, diagnosis and treatment during the crisis response. However, in the longer term, there are other reasons why telehealth services can be helpful.

For instance, telehealth can be a key enabler for the preventative model advocated in the NHS Long-Term Plan. The tasks of preventative care include regular activities, often carried out by people without their health and care professionals. In this context, mobile health applications offer opportunities to support preventative care and can be used to address common health issues such as smoking cessation and improving healthy eating habits. Additionally, online peer-support networks offer resources, advice and are a further example of a digital approach to prevention. Therefore, to sustain the telehealth revolution, rooting it in the broader prevention agenda is essential.

#### **The successful continuation of telehealth services will be reliant not only on bedrocks such as core, basic infrastructure, but also on achieving equal access for the whole population.**

Many marginalised groups may face challenges accessing telehealth. Providers and policymakers must carefully consider how the telehealth policies and routines they implement might have potentially negative implications for equal access. The decisions made during this pandemic will have long-lasting impacts. We must all work together to ensure everyone is brought on the journey.

14 - Ipsos. July 2020. COVID-19 sees surge in remote consultations by doctors: Ipsos survey. Available from: <https://www.ipsos.com/en-in/COVID19-sees-surge-remote-consultations-doctors-ipsos-survey>.

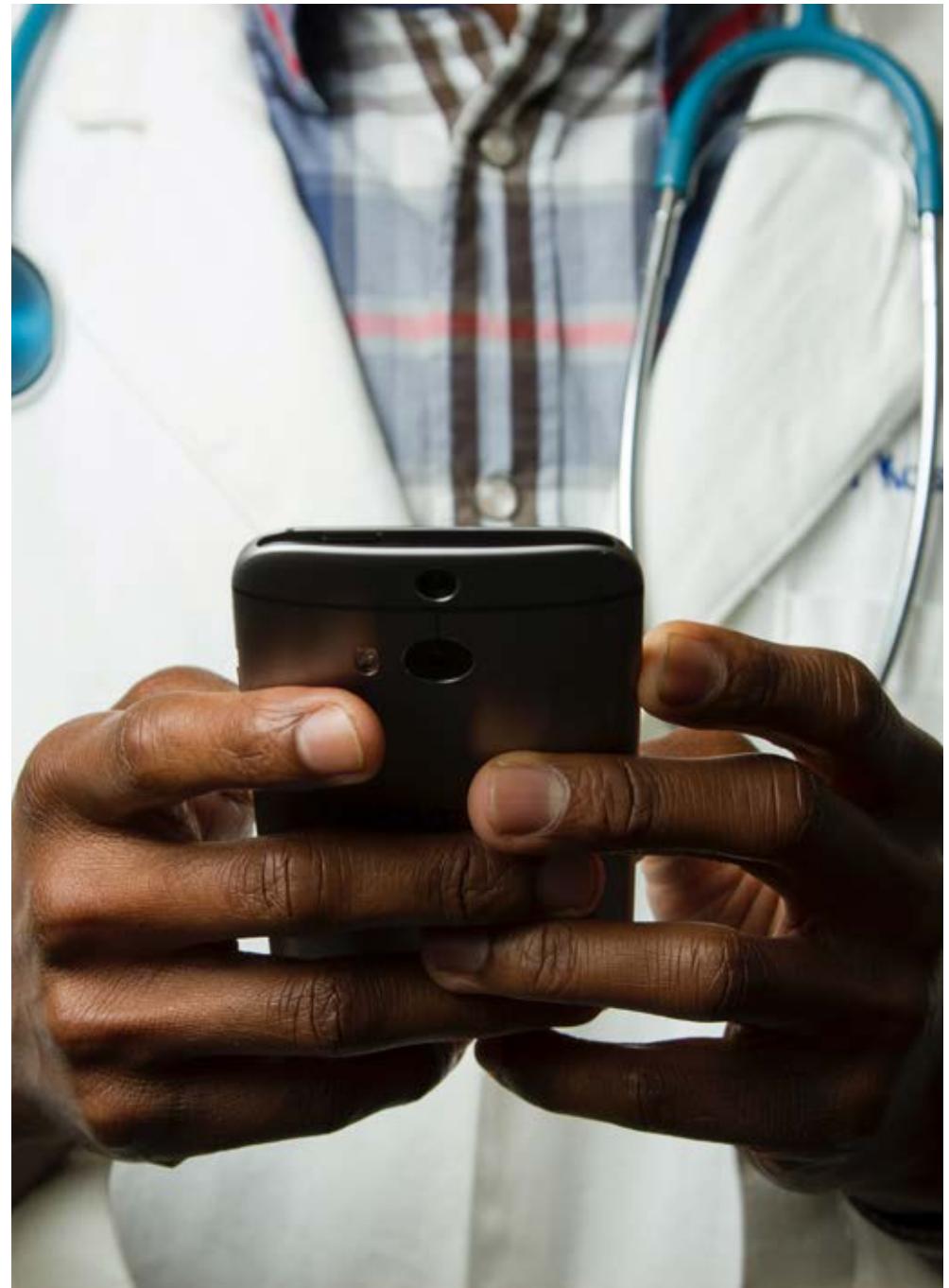
The future of telehealth will see more hands-on patient use of technology to maintain good health. This will come in the form of wider usage of mobile health applications and engagement with peer-support networks. Sustaining and developing telehealth is dependent on all of us, as providers and service users of health and care.

**As providers, it will be essential to continue to collaborate and share data to better understand health outcomes, access and patient experience using telehealth platforms.**

It is also essential that clinicians are aware of these technologies as part of their treatment plans and the benefits they can provide. As service users, we need to actively engage in the design of telehealth services to ensure the same level of quality as the "traditional" model is being provided.

**Building trust in a new form of healthcare delivery does not happen overnight, it will take time and significant effort.**

It is essential for all service users to be fully involved in the process, given options to engage and opportunities to feedback.



# ORGANISATIONAL DEVELOPMENT

## RE-LEARNING HOW TO LEARN

### NATASHA LARKIN

Natasha Larkin is PPL's Head of Organisational Development. She has over 15 years of experience in supporting individual, team and organisational learning and development across the public, private and voluntary sectors. Over the past few months, she has supported health and care organisations to translate their learning and engagement sessions online.

#### **I recently read a BuzzFeed article which pitted Millennials against Baby Boomers.**

Reading through it, I found that I could recognise some of the Millennial traits in myself, but not all of them. It turns out I am part of a "micro-generation" – known as Xennials – who sit on the cusp between Generation X and Millennials. If you were born in the late 70s to early 80s, you might belong to this generation too.

#### **You might be wondering what this has to do with organisational learning during COVID-19.**

Well, for me, the Xennial tagline "analogue childhood, digital adulthood" is a great starting point for understanding the journey I've been on as a learning professional during lockdown.

At the risk of over-generalising, Xennials tend to be very comfortable with technology but it's not as second nature to us as it might be for those who grew up online. I'm on Instagram, but I have no idea what TikTok is, and no desire to find out. Similarly, professionally, I am no stranger to learning technologies, having designed e-learning games, but for the most part, my approach and preference when it comes to supporting learning is face-to-face.

#### **Back in March, when lockdown went from "might happen" to "any day now", my analogue past jumped up and shouted, "this will never work!"**

I vividly recall sitting in a meeting room (remember those?) with colleagues talking about using online platforms for training and meetings and breaking into a cold sweat.

When it comes to supporting learning, whether that's through training, facilitated discussion or just learning day-to-day, there is something incredibly powerful about being in a room with other people. It's about sensing the mood change, without anyone saying anything.

It's about being able to use the physical space to connect with people, making eye contact, showing people that they've been heard and understood. It's the ability to use movement and space to help people to maintain energy, work creatively and see their ideas develop around them.

It's also about those informal conversations that generate learning and new thinking outside of the classroom or meeting room. And finally (but by no means least) it's about post-it notes. Sorry planet.

I've never been afraid of a challenge, though, so I cast my fears and 15 years of preconceived ideas about training aside and threw myself into the virtual world of learning and organisational development.

#### **Over the past few months through a variety of online formats – training, workshops, buddy lunches and coffee catch-ups – I discovered many benefits to working in this way.**

##### **1. Online sessions can lead to greater attendance.**

When working with busy frontline clinicians, finding diary time can be an immense challenge. When you're not having to contend with room bookings and travel time, it's generally much easier to get people together and fit training and meetings in between other appointments.

##### **2. Equity of participation.**

It is the eternal challenge of the facilitator to find a way to make sure that everyone has a voice, particularly the quieter group members. One of the things I love about facilitating online is the ability for people to contribute in different ways. The chat functions are a great way for people to share their ideas when they might not feel confident or comfortable to vocalise their thoughts. The use of online polls is another great way to gauge the feelings in the room without everyone having to speak out.

### 3. Seeing humans as humans.

Seeing people working from their own homes – with kids and pets in the background, or deliveries arriving at the door – can be a great leveller. In a world still dominated by hierarchy and status, it can sometimes be a useful reminder to us all that the people we are learning with, and from, are just people too.

### 4. Technology can be really fun!

Just before writing this blog, I attended a meeting called “playing with post-it notes”. We’ve just discovered a tool that enables collaboration using virtual post-its. Not only did we learn a new tool that we can use to enhance our training and meetings, but there was something about the process of experimentation that freed us up to be more playful in our approach. When you change the medium, you often change the mindset too.

#### **Am I now a convert to online learning? Sort of.**

Maintaining a learning environment and culture when you don’t see people every day isn’t easy, and it doesn’t just “happen”. It takes planning, creativity and a whole heap of trial and error.

So ultimately, I can’t wait to get back to working with people in 3D, but there are benefits to connecting with people virtually that I wouldn’t want to lose.

**“In the rush to return to normal, use this time to consider which parts of normal are worth rushing back to.”**

I’ll definitely be leaving some of my analogue habits in the past.



## "IN THE MIDDLE OF DIFFICULTY LIES OPPORTUNITY" (ALBERT EINSTEIN)

### JESSIE CUNNETT

Jessie Cunnett is Head of Health and Social Care at [Traverse](#), an employee-owned organisation which supports the public sector in areas including Consultation, Evaluation, Engagement, Organisational Development and Social Investment. During the pandemic Jessie led rapid research studies to shine a light on how people have experienced accessing services under lockdown

#### Can a crisis be an opportunity?

My professional experience would suggest, yes, very much so. It is often when things can't get any worse, when the usual rules are laid to one side, that courage and appetite for innovation come to the foreground.

There have been a few memorable and highly charged examples of this in my career. When I look back, these moments are when I have done the work I am most proud of.

**In the wake of the failings at Mid Staffordshire, together with the people affected by what happened, we were able to conceive, create and launch Engaging Communities Staffordshire.**

Eight years on and now known as [Engaging Community Solutions](#), it is a thriving social enterprise that brings together community engagement and consultation, social research, independent advocacy and Healthwatch services. It is one of the largest providers of local Healthwatch services in the country, supporting hundreds of thousands of people every year to have their voices heard. Creating it was possible because the status quo wasn't an option. Patients and families wanted to be heard and to own the solution.

**More recently, in the shadows of the scandal at Morecambe Bay and its devastating impact on families, the concept of person-centred regulation was realised and the establishment of the [Public Support Service](#) was made possible.**

This happened because the Nursing and Midwifery Council was ready to be brave. It was clear that business as usual wasn't an option. With no blue-print for how to solve the problems, there was an opportunity to push hard at the boundaries of possibility. To achieve this change, we established a steering group including people who had experienced devastating life-changing events. They were able to help guide and challenge us. We then set up a team to be a point of personal support for people through the fitness to practice process, a 24 hour helpline to provide much-needed emotional support, and an advocacy service so that people who found it hard to express what had happened could work with an advocate.

#### All this was achieved in twelve months.

It would not have been possible without a sense of opportunity for change borne out of crisis. This team has been shortlisted this year for a prestigious HSJ Patient Safety Award.

And now we find ourselves, despite shops, pubs and cinemas re-opening and some sense of normality returning, still in the depths of a global pandemic. The implications for health and care in every region of the country are far-reaching. In many respects, services will never be the same again.

**As we learn to live with the impact of COVID-19, there is an opportunity to identify problems with new eyes and spot possibilities where we couldn't see them before.**

The use of digital technology in the delivery of health and care services may be one such example. Social distancing and a restriction of face-to-face contact as a strategy for managing the spread of the virus have led to a rapid increase in the use of digital technology. This represents a key change to the way services are being provided. They are moving from a traditional model of face to face care to a "digital by default" option at pace as remote and virtual consultations and appointments become the norm.

**The key to locating opportunity in crisis lies in our willingness to learn from the experiences of those who have been affected and have had to adapt.**

This will enable us to understand what people are looking for and find solutions that will not just meet their needs but improve on what was possible before.

**In the course of our recent work, the Doctor Will Zoom You Now, we have been engaging with patients to understand their experience journey of remote consultations.**

This project has highlighted a real appetite for what virtual appointments have to offer to clinicians – namely, better use of time, records of conversations, time to plan and prepare, and more focused attention. However, these opportunities can only be truly successful if they are balanced with how to make appointments work for patients. They must allow for quality personal communication, respect for people's time, information about what to expect, willingness to learn and adapt through feedback, and, perhaps most importantly, consideration of those who may be left behind because they will never be able to access remote consultations.

**As an optimist, I look to find the good in any situation.**

Through my work at Traverse, I feel grateful to be able to look for the opportunities in the crisis that we find ourselves in. And I am confident that together we can shape a better future from it.





# **LIST OF CONTRIBUTORS**

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Charlotte Augst is the Chief Executive of [National Voices](#), the coalition of charities that stands for people being in control of their health and care. Prior to joining National Voices in March 2019, Charlotte led the work of the Richmond Group for five years, developing strategy, facilitating discussions and representing the Group externally. During the pandemic, she has led National Voices to advocate for the parts of society most impacted by COVID-19.

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Imelda Redmond is National Director of [Healthwatch England](#), the independent champion for people who use health and social care services. Imelda has 20 years' experience working in senior roles in the not-for-profit sector. She was previously CEO of the charity 4children, Director of Policy and Public Affairs at Marie Curie Cancer Care, and Chief Executive of Carers UK where she received a CBE for her services to disadvantaged people in 2009.

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David Segal is a Manger at PPL. He leads PPL's Integration, Partnerships and Primary Care practice. David is an expert in system change and integration, specifically in the use of co-production to improve outcomes for people and communities. David has been supporting health and care systems in England to tackle COVID-19 while working towards a "better normal".

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Laura Walsh is HR Manager and Consultant at PPL. During the height of the pandemic she led PPL's operations team volunteering with Surrey County Council, sourcing donations and support as part of the council's emergency response.



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