Health Foundation long read (PDF version)

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Understanding and sustaining the health care service shifts accelerated by COVID-19

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Contents

Key points

- The coronavirus (COVID-19) pandemic has led to significant changes in how NHS services are delivered and used. This has seen an acceleration of policies that have previously only made incremental progress.
- Service shifts have affected the whole care pathway. This includes changes to health promotion and support for vulnerable people in the community; remote consultations in primary and hospital care; new ways of receiving emergency acute and mental health services; and new collaborations across the health and care system.
- A number of 'enablers' made these changes possible despite the huge strain on the system. These included local freedoms to implement changes within national guidelines, more time for clinicians to innovate and permissive 'air cover' from regulators to do so.
- Barriers to sustaining these 'service shifts' include fears of digital exclusion for some patients, challenges arising from collaboration across organisations and the potential fragility of the new community support networks because of financial pressure on the voluntary sector and future loss of volunteers.
- As the NHS moves into the recovery phase and starts to address the backlog of care and unmet need, it will need to maintain openness to radical innovation and learn from what made such a response possible. The need to improvise and adapt will continue for the foreseeable future.
- A model for sustainable change will need to bring together different factors to maintain new ways of working. These factors include having the backing and confidence of both clinicians and patients in service shifts forged during the crisis period, the availability of tools and resources and the alignment of systems of regulation and incentives.

Introduction

The response to the COVID-19 pandemic has seen dramatic changes in how health and care services are delivered and used. These changes – or 'service shifts' – have in many instances incorporated a fundamental redesign of services, with profound implications for both staff and patients.

While the prime catalyst for change has been the urgent need for infection control, it is notable that some of these service shifts have long been NHS priorities, on which there had been limited progress prior to the pandemic. The pandemic has provided a new context that allowed previously long-held assumptions and norms about how care should be delivered to be urgently reexamined and, if necessary, changed.

This gives rise to two questions. First, what has enabled the health and care system to respond so quickly to these new demands and overcome prior barriers to implementing change? Second, what will it take to ensure that beneficial changes are sustained as this context continues to change?

Our approach

To provide some answers to these questions, we conducted interviews with NHS staff and patient stakeholders across Great Britain, also drawing on 'grey literature', media reports, and outputs of stakeholder events convened by the Health Foundation and other organisations. We collected examples of major service shifts across the health system and then explored factors that might explain why these shifts have occurred, as well as issues that could inhibit their retention.

Even though the context is fluid and examples of service shifts are emerging all the time, this snapshot illuminates a number of consistent themes. We use these to develop a model of sustainable change that could guide national and local leaders so that positive change is protected once the immediate crisis abates.

What service shifts have taken place?

The key service shifts we have identified are briefly summarised in Figure 1. This is not intended to be a comprehensive list of the myriad changes (reviews by the NHS are underway).

Instead, we focus on identifying those shifts in practice during the pandemic that can be linked to prior strategic objectives. These shifts are summarised below.

- **Health promotion and disease prevention**: as understanding of COVID-19 developed it was clear that factors such as underlying health conditions and obesity made people more vulnerable to serious illness. Public discourse about maintaining mental and physical health during lockdown burgeoned, as did collaboration within communities to protect the vulnerable. More than 4,300 community networks were established involving an estimated 3 million people alongside which approximately 1 million NHS volunteers were recruited. Examples of local collaboration within communities abounded, and measures of community cohesion reached a new high. Digital tools to help people manage their conditions and symptoms were used more extensively and new ones created. Interviewees described outreach services created for vulnerable groups, led by social prescribers and other primary care and mental health staff.

- **Primary and community care**: wholesale changes to primary care were mandated from the beginning of March, with the introduction of digital triage, the rapid expansion of remote consultation, and the creation of 'hot hubs' to manage potentially infectious patients across GP practices. Some routine care was suspended. GP appointments fell in March, and again in April, by about 30% with the proportion of consultations carried out face to face falling from 70% before COVID-19 to 23% during the pandemic. Community NHS trusts were given leadership roles to implement coordinated hospital discharge ('discharge to assess') and redeployed resources to support admission avoidance and the transition from inpatient care ('step down' services).

- **Diagnosis and treatment by hospital specialists**: hospitals saw significant increases in demand for critical care facilities and, at the same time, reduced demand for (and postponement of) non-COVID-19 services. Elective (non-urgent) admissions for May 2020 decreased by 71.8% compared to May 2019, and GP referrals reduced by 71%. Many outpatient services transitioned from face-to-face to digital modes very rapidly and were further reduced through broader implementation of 'patient-initiated follow-up' and digital 'advice and guidance' by consultants for GPs. Extensions to the 'call before you walk' scheme were piloted to allow 111 services to directly book patients into A&E. New crisis services for mental illness were developed.

- **System shifts**: changes have been made to the broader organisation of services across local health and care systems. Greater collaboration between GPs through supra-practice organisations was evident in all countries of the UK. Hospitals concentrated some specialist services on designated sites and have explored the creation of longer term specialist networks (such as for gastroenterology, interventional radiology and vascular surgery). Waiting lists have also been shared across local health and social care economies areas to manage elective care more efficiently. There has also been a fundamental shift to remote working by managerial and clinical staff that has seen the rapid deployment of technology (laptops, software, information governance etc) across whole workforces.

Table 1: Examples of the service shifts emerging during the COVID-19 pandemic

	Promotion/Prevention/ self management	Primary and community	Specialist diagnosis and treatment
Patient-clinician shifts	• Outreach from primary care and mental health for vulnerable groups • Online health promotion resources • Community support networks (health specific and general) • Remote self-monitoring and management tools	• 'Total triage' for general practice • Digital consultations • 'Discharge to assess' • Electronic prescribing • Increase in referral thresholds • Increased skill mix within teams • Community admission avoidance and step down care	• Remote 'Advice and Guidance' for GPs • Virtual outpatients • 'discharge to assess' • Specialist hubs for specific conditions (eg cancer) or elective care • Enhanced 'Call Before You Walk' to A&E • 24-hour telephone crisis care for mental health
System shifts	• Collaborative hubs for locality services in primary care • Leadership roles for Community Trusts in discharge management • Specialisation of services across hospitals (eg hot/cold, elective, specialist networks, downgrading of A&E) • Centralisation of waiting lists across STP		

What has enabled these shifts to occur?

Most interviewees referred to a 'needs must' attitude where solutions, even if previously contested, were embraced if they enabled patients to be treated more safely. In this respect, the key enabling factor was the galvanising force of a public health emergency, despite the huge strain on the NHS. However, beneath this lie more subtle factors that enabled change. These are important to understand if positive service changes are to be sustained.

Top-down clarity and bottom-up agency

Many respondents reported that central guidance issued during the pandemic, although sometimes Many respondents reported that central guidance issued during the pandemic, although sometimes voluminous, had the benefit of providing clarity over processes to be followed and lead responsibilities. This helped to break through what was sometimes described as 'organisational inertia'. The standard operating procedures for primary care and the 'discharge to assess' instructions for hospitals, community and social care are examples of this.

Interviewees pointed out that these overarching frameworks left space for local agency, enabling a 'can-do' attitude but also, importantly, an enhanced capacity to lead change locally but within the national guidance.

Clinical perceptions of service quality

Prior scepticism among some clinicians about digital solutions, such as email and video consultations, has been shifted by experience. These tools were now perceived, at least by some clinicians, to be effective. Many hospital consultants and general practitioners found that routine matters could quickly and satisfactorily be dealt with remotely, leaving more time for complex cases. As one clinician remarked, a video consultation felt like 'a proper consultation'. They also perceived this change to be convenient for and popular with many of their patients; a view broadly echoed by those patients who value the convenience of digital consultations. Similarly, discharging stable patients (with the option for the patient to re-engage if needed) allowed time to be prioritised for patients with higher needs.

Other benefits were identified by professionals. GPs valued the ability to share documents safely with patients using approved software (such as sick leave documentation, referral letters and advice leaflets) and to receive photographs that could be combined with patient notes. The use of digital modes of consultation also allowed flexible working, including at home, for professionals.

Regulatory 'air cover'

Fear of falling foul of complex regulation has historically acted as an important dampener on the adoption of new practice. Covid19 changed the 'risk calculation' for many care givers: face-to-face practice became significantly more risky and new forms of practice relatively more attractive. Processes associated with clinical governance, medical negligence and information governance were all cited as significant barriers that were lowered during the pandemic. Here, regulators facilitated this change. One clinician described the sanctioning of video consultation by NHSX as 'liberating' and found protocols for such consultations by the British Medical Association and Royal College of General Practitioners helpful. The medical defence organisations issued guidance and suggested wording for patients' notes that mitigated against the risk of clinical negligence claims. Similarly, agreements were put in place to allow clinicians to work seamlessly across different hospital trusts without requiring additional training or other clinical governance requirements (known as 'passporting').

Financial incentives

Many respondents referred to the lubricating effect of virtually uncapped funding, which allowed the rapid adoption of national and local schemes. This meant that the bureaucratic brake of local testing for value for money or affordability was lifted. The suspension of other financial incentives (such as the CQUIN framework and Quality and Outcomes Framework (QoF) in England and the Quality Assurance and Improvement Framework in Wales) and the simplification of English NHS trust contracts to 'block contracts' were also felt to have supported rapid innovation – ie allowing for the creation of new solutions without the fear that any organisation might be financially penalized by existing contract terms.

Enhanced clinical capacity for service change

The significant reductions in demand and planned activity, notwithstanding concern about unmet needs, provided important headspace for clinicians to plan and implement new ways of working. For GPs, lower consultation rates resulted in a significant reduction in clinical workload, and reduced bureaucratic requirements meant much fewer administrative tasks (the latter agreed with commissioners and CQC). In hospital, reductions in routine work for those front-line clinicians not engaged in the emergency support of COVID-19 patients provided time to plan and execute new approaches to services. Alongside this, clinicians in both primary and secondary care referred to reduced burdens in appraisal and revalidation, clinical governance and other bureaucratic requirements. As one clinician put it, the reduction in unnecessary 'box-ticking meetings' gave more 'time to think'.

Awareness and appetite to tackle inequalities

The unequal impact of COVID-19 on different populations, together with the understanding that this can be attributed to wider inequalities such as wealth, housing and occupations, has proved an important part of the social narrative of the pandemic. This generated a wider concern to address inequalities in health more determinedly, including through better community organisation to support vulnerable people at home and through joint working between public and voluntary organisations. One interviewee talked of a new appetite for sustained change that went far beyond the proliferation of pilots that had characterised their work in this field previously.

What barriers to sustaining the shifts might be encountered?

A number of possible unintended consequences of these changes were identified as well as potential sticking points that may make their sustainability less likely as the emergency nature of the response diminishes.

Concern about digital inclusion

Many interviewees highlighted the risks of digital exclusion – a topic extensively reviewed as part of the wider discourse on the digitalisation of public services. According to the Lloyds Bank UK Consumer Digital Index of 2020, 4.8 million people never go online and 11.3 million lack basic skills to use the internet. There appears to be a correlation between disadvantaged groups and lower digital skills.

Experience of clinicians suggests that, while telephone and video consultations work well for many patients, it is clear that for some cohorts or individuals they are suboptimal or simply not appropriate (examples raised include people with autism, dementia and other cognitive deficits).The reduction in or loss of visual cues was also raised as important in dealing with some patient issues.

Another worry was the cost implication of consultations for those on 'pay as you go' mobile telephones and those without home broadband or smart phones. There is a danger that an inappropriate reliance on digital services could increase inequalities.

The over-application of digital consulting may also have negative implications for some staff too, for example, on the professional satisfaction of GPs whose interaction with patients is almost entirely consultation based. As one clinician remarked 'I've done eight video consultations today but spoken to no one.'

Some evidence suggests that triage and 'telephone first' consultations may not reduce GP workload overall. One possible outcome, as demand for services rises again, is that workload pressures will return and perhaps be exacerbated, especially if new digital service models are not properly designed into care pathways. Debate is underway about what the 'correct' proportion of digital consultations should be.

Limits to system-wide collaboration

The acceleration in the collaboration between hospitals may prove one of the more contentious shifts for the medical profession. The development of specialist centres with a sub-specialisation of doctors will impact on long-held ties between clinicians and hospital trusts. Shared waiting lists may

be perceived as disrupting doctor-patient relationships by separating initial assessment from later surgery. Those specialists remaining in largely generalist roles may face reduced professional satisfaction and status (and potentially an impact on income if private practice is disrupted).

The concentration of specific specialties in designated NHS trusts is also likely to be contentious for trust boards. Some interviewees saw COVID-19 as being used as an excuse for introducing strategic changes that were already preferred. Even where there may be a growing (if fragile) consensus about future reconfigurations among local trust boards, many doubted whether this would be replicated among local politicians and the public if it affected services at cherished local hospitals. Judicial review was also raised as a risk to progress if normal consultation processes were not followed.

There was also some evidence of resistance to shifts of care across sector boundaries. While better communication between GPs and consultants was largely seen as a positive outcome of the pandemic, in one case the enhanced use of 'advice and guidance' proposed by the hospital was reportedly resisted by some local GPs, because they would be forced to take more clinical responsibility without additional resources in the long term. As one clinician wryly commented: 'GPs get repositioned as the consultant's houseman!'.

Maintaining community solidarity

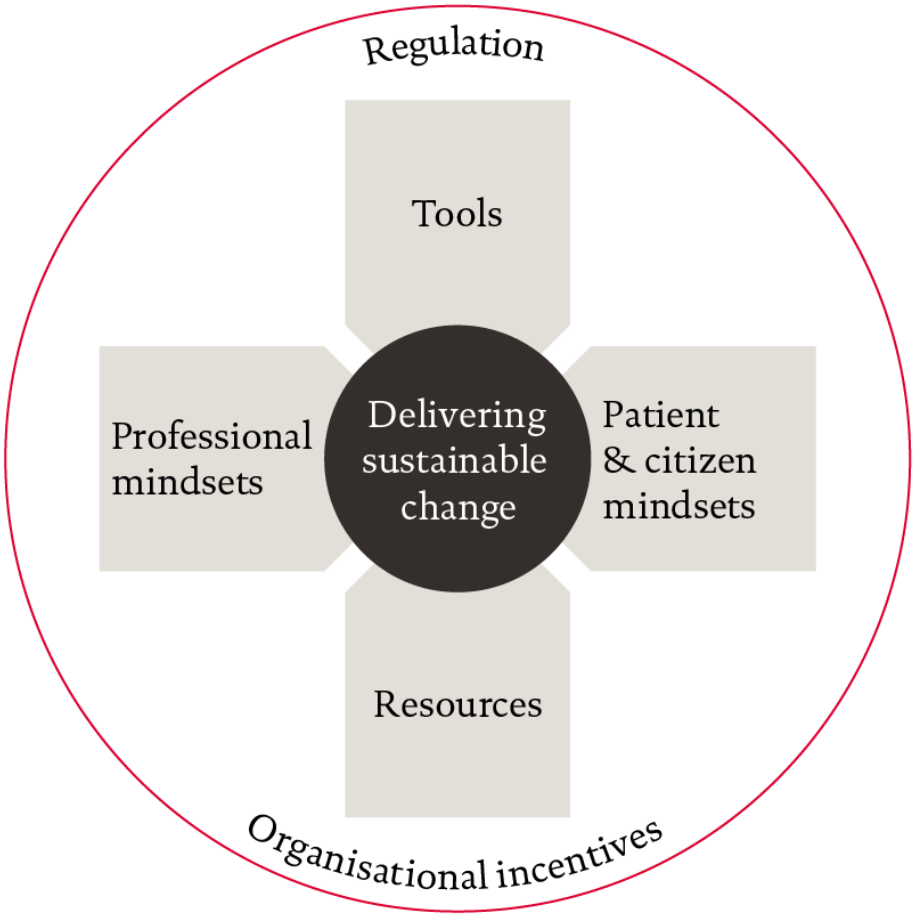
While the increase in social solidarity and community activity to help the vulnerable is a more remarkable development of the pandemic, it is by no means clear that these will persist once a more 'normal' environment returns. The importance of such groups to patients was emphasised – not just for providing practical support (such as providing food, advice, social support, medicines collection) – but in terms of engendering wider empathy for the experience of exclusion and home confinement. As one interviewee remarked, vulnerable people are 'are scared that [community support] will go and [they] will go back to being invisible again'. While community organisation may have increased, charities of all sizes have suffered and some face an uncertain future (the National Council of Voluntary Organisations estimates that the lockdown may result in lost revenue of at least £4.3bn).

Creating a model of 'sustainable health policy change'

It is clear that COVID-19 has significantly changed the context in which the NHS operates. Context is important in any understanding of policy because it shapes what is possible and refers to factors that constrain or support the achievement of a goal. As the context of national emergency begins to be replaced by one of 'recovery' and more (although by no means complete) 'normality', there is a risk that practice will revert to the status quo ante and that positive changes made during the pandemic will be lost. Already, interviewees referred to the 'return of the forms' for monitoring of spending and performance. NHS England has stimulated a programme designed to identify and embed beneficial changes; but careful thought is required about how adoption and sustainability might be achieved. Prescribing change from above without local agencies and staff 'owning' and being able to shape the solutions is unlikely to be successful, even if the extreme financial and operational pressures of the next phase make this tempting to system leaders.

We have brought together the insights into the enabling factors and possible barriers generated by this project to hypothesise a high-level model for delivering sustainable change (Figure 1).

Figure 1: A high level model for sustainable change



Mindsets

At the centre of this model lie the 'mindsets' of NHS staff . These mindsets comprise the beliefs and assumptions generated by experience. Clinicians wield significant discretionary power, including in some circumstances the power not to act nor to comply with demands. If the beliefs and assumptions held by clinical staff are not aligned with the assumptions that underpin the new service models, then the sustainability of those new ways of working is threatened.

While the mindsets of clinicians are important, so too are the mindsets of patients and their carers. If patients do not accept new modes of care they have a number of options including: bargaining (eg negotiating 'work-arounds' with clinicians that maintain old ways of working); opposition (eg formal protest including through the political system) and exit (simply not presenting for services).

Examples of the beliefs and assumptions that might be needed for these service shifts to be sustained are illustrated in Figure 3. Some of these beliefs and assumptions may have been largely established through the pandemic, but others remain in doubt, with more convincing required. Especially as debate shifts to longer term arrangements, professionals may question whether resources will be shifted to support new service models, or fear that careers will be less satisfying and smack of 'call centre medicine'. Patients and citizens may need reassurance that services have been designed with patient input and priorities in mind.

Table 2: Illustrative mindsets, beliefs and assumptions of professionals and patients

	Likely largely in place	Likely still required
Professional mindsets	• Digital consultation can offer high quality clinical interaction • More care can successfully be provided in community settings • I can make and sustain service changes without unnecessary interference • I can and will work collaboratively with clinicians in other organisations	• Inequalities relating to digital access can be adequately addressed • Demand can be managed if access to my service is improved • My career will be fulfilling if I collaborate across organisations and go 'digital first' • New expectations of my service will come with the resources required
Patient and citizen mindsets	• Digital consultation can offer high quality clinical interaction • Taking more control over my own care is safe, empowering and convenient • I do not need to go to hospital to get the care I normally need	• Sufficient flexibility exists if I do not believe digital consultation is appropriate for me • New forms of community support will not disappear

Tools and resources

For change to be sustained, mindsets need to be supported by the right resources and tools. Tools include widespread access to digital consulting software, the use of 'advice and guidance' from hospital consultants to GPs (especially local developments which ensured interoperability with GP systems) and the adoption of relatively inexpensive devices such as pulse oximeters and blood pressure monitors and apps through the NHS app store to support patient self-management. Even widely available tools, such as WhatsApp, have been effective in connecting hundreds of neighbourhoods to support vulnerable people and shielding groups.

The availability of funding has also proved important in bringing about change – the NHS was essentially offered a blank cheque – but this period of plenty will not continue indefinitely. New activity flows and responsibilities will need to be underpinned by new resources. Some new services (such as step-down from hospital) relied on redeploying staff from services that had temporarily been suspended. Realism is needed about the workforce needed for both new and restarted services. Testing and refining new service models will itself require additional resources.

It is also clear that the time and support for learning, collaboration and improvement is also a key resource. Additional time was created by reductions in activity levels and bureaucracy, and ways to protect this time will need to be found if these changes are to spread, deepen and sustain.

Regulatory framework and organisational incentives

Many of the service shifts identified in this long read introduce new risks, such as patient assessment without physical presence, new types of staff substituting for another and rapid relocation from one setting to another. Many interviewees said the special measures introduced by regulatory authorities in relation to clinical risk and information governance were important. Without continuing regulatory 'air cover' changes are unlikely to sustain. Regulators and professional bodies could go further to support embedding change, by setting out more definitive guidance for practitioners (on effective digital consultation for example).

Lastly, NHS and care organisations need to face incentives that do not work against the sustainability of service shifts, and preferably support them. Financial incentives have a part to play and there is an opportunity with the suspension of the current NHS financial regime to ensure that whatever replaces it is well designed (for example, for many years the pricing of outpatient appointments discouraged hospitals from offering virtual consultations and 'advice and guidance' to GPs in preference to formal clinic appointments).

Other organisational incentives matter too, such as formal targets, performance management regimes and informal measures, such as what is celebrated or leads to career advancement. A common theme

from evaluations of new ways of working suggest that local teams are inhibited if senior management faces different organisational incentives or is simply distracted by competing priorities.

Conclusions

As we enter the post-crisis phase of the pandemic, the NHS needs to establish a new equilibrium as the tolerance for 'good enough in a crisis' diminishes, and permanent and more nuanced solutions are required. This is particularly the case for the use of digital solutions, where an inflexible reliance on remote consulting would disenfranchise some patients, likely the most vulnerable or those with individual needs. Co-design with patients and the public will be vital as the systems evolve.

NHS staff have sometimes been portrayed as the stumbling block to change. However, it is clear that when empowered to do so, NHS staff are able to lead radical change, quickly and effectively. But will the mindsets among staff that have enabled these changes persist beyond the crisis? The newly acquired 'headspace' for front-line actors and a belief they are trusted to implement change, will need to be preserved even as demand rises.

The relationship between the policy 'centre' and the 'periphery' matters. Perhaps unusually, many interviewees described a productive relationship between the top-down and bottom up, even during a time of emergency central powers. How this equilibrium develops will be key if staff are to remain empowered and able to lead change from the front line. Certainly, there are signs that greater monitoring and performance management is re-emerging and it is unlikely that the NHS will simply be allowed to 'get on with it' without close scrutiny. The challenge for government and central NHS bodies will be to hold the NHS to account without resorting to ineffective micromanagement.

Another 'big story' of the pandemic has been the high levels of social cohesion and a surge in self-organised neighbourhood groups (alongside a national NHS volunteer cadre). The focus on health and other inequalities has sharpened considerably, including a determination to address the wider determinants of health and finally turn the tide on widening health inequalities. This is likely to require significant investment in community infrastructure and in third sector capacity, the latter already struggling with the effects of the lockdown. It is clear that the NHS is facing enormous challenges over unmet need that may take years to address (the NHS Confederation estimates that waiting lists for treatment could rise to 10 million). The service shifts catalysed by the pandemic itself are unlikely to be the last and an 'agile' approach to change is required given the huge challenges facing the service. This includes in safely restarting surgery and supporting shielding patients while the pressures of winter and the threat of the pandemic still loom.

This will involve a new attitude to managing 'policy risk'. Not all required changes to practice will come with sufficient accompanying evidence (at least not 'gold standard' evidence). As recently pointed out by Professor Trisha Greenhalgh, the absence of a randomised controlled trial is not always sufficient reason for doing nothing. New systems for rapid change, evaluation and communication will be required.

Finally, public discussion of medical science, epidemiology and the management of risk has become a daily occurrence. This could provide the foundations for substantive and intelligent public discussions over options for health and health care delivery in the future. During the crisis, many changes have been implemented with necessary speed and with little chance for formal public and patient testing or engagement. There is now an opportunity to refine the change management approach – involving patients and the public in designing longer term approaches as positive service shifts are identified and consolidated.

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