COVID-19
LEARNING AND EVALUATION

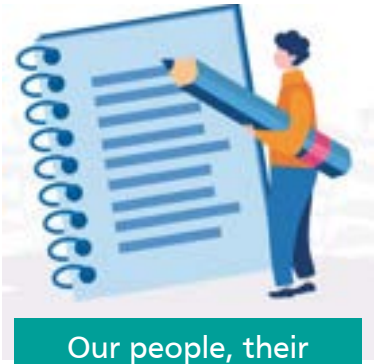
Learning and evaluating during the pandemic

The scale of the COVID-19 outbreak and its impact is unprecedented and has changed the way in which we are able to look after those in our care. It's meant that we've had to redesign the way that we deliver existing services, and open up some new ones.

As a result of these changes, Anna Badley and Dr Sarah Williams have been leading on the Solent COVID-19 Learning and Evaluation project, which aims to rapidly evaluate the things that are changing so that we can collect, analyse and learn from these changes as we navigate this unprecedented situation.

Rapid Evaluation

COVID-19 Rapid Evaluation overview



Our people, their stories

Our services, their stories

Spotlight on Redeployment

Spotlight on Working From Home

Spotlight on Remote Consultations

Spotlight on Frontline Teams

Rapid Evaluation

Our plan for learning during the pandemic

At the beginning of the COVID-19 outbreak there were few community trials in process, so our team looked at ways to learn from the changes that were happening, as well as feed in to adaptations and improvements across the Trust. This was our 'master plan'...

Rapid Appraisal

- Telephone and video calls with staff and patients
- Surveys to gather feedback
- Reviewing service data and how it's being used

"At its heart, AI is about the search for the best in people, their organisations, and the strengths-filled, opportunity-rich world around them."

Appreciative Inquiry

Looking at what worked well and why, learning from excellence, and creating and sharing case studies and examples.

Rapid Ethnography

ethnography
eth-no-gruh-fee
the scientific description of peoples and cultures with their customs, habits, and mutual differences.

- Surveys to gather feedback
- Blogs and vlogs - our people sharing their stories
- Taking part in events

Co-Design

- Including patients and the community as we reopen services
- Carrying out peer interviews
- Using Zoom to plan Experience Based Co-Design
- "Staying Connected" with patient groups through newsletter

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How did we carry out the Solent Evaluation?

The methods...

Our approach

As it became apparent that the coronavirus pandemic was going to have a significant impact on the daily functioning and wellbeing of staff and patients at Solent, it felt important to capture our story and our learning. The evaluation was grounded in the following principles:

Learning organisation

- Continuous improvement is grounded in good quality evidence.
- We learn just as much from what goes well as we do from what is challenging and hasn't gone so well.
- Learning is shared across the whole organisation.

A climate of rapid change and new territory

- Any approach needed to be flexible and able to feed back rapidly.
- The unique situation made it imperative to take a structured approach to learning.
- Context had to be captured to provide a memory and back-drop to the decisions that were made.

Shared ownership

- The pandemic was experienced by all, and so the evaluation needed to allow people across the organisation to tell their story and share experience.
- The evaluation team needed to be part of the experiences by being present - not always working remotely (ethnographic approach).

Openness and honesty

- Inevitably some messages were going to be difficult. These would not be sanitised, but would be shared openly, fairly and respectfully.
- There would be full transparency of methods and limitations.

Ethics

The evaluation followed the Trust evaluation registration process, and followed our policy standards for consent, data protection, confidentiality and dissemination.

These align to the national principles as outlined in the UK Policy Framework for Health and Social Care Research (2020).

The team

The evaluation team comprised of:

> Two evaluation leads; they set the strategic direction of the evaluation, provided oversight and carried out the final analysis and write up.

Evaluation period

The core evaluation took place between the first interview on the 16th April and the end of July 2020. Learning and events between August and December have been included as part of the write-up where appropriate.

A data collection team to carry out interviews, produce event timelines and do some 'spotlight' studies.

A data coding and analysis team to begin to pull out key themes and code the qualitative data.

Mentorship from the RREAL team at University College London. This team carried out some of the interviews but also provided mentorship and support in regards to the Rapid Evaluation methodology. Their input helped to ensure robust data collection methods and analysis.

Data collection:

The approach we took needed to be flexible and varied. It also needed to be pragmatic and set up at pace. We chose to carry out:

1. Interviews around experiences carried out primarily with staff.
2. Observations of events, services and remote consultations.
3. Spotlights and case studies on particular services and responses.
4. Surveys of staff and patients.
5. A series of blogs, own account narratives about experiences of the pandemic and lockdown.
6. Collation of a trust time line; recording what happened and when.
7. Collation of quantitative data for deep dives into particular topics, for instance, remote consultations and re-deployment.

Interviews

Recruitment

In total we carried out 112 interviews; these were held remotely on either the phone or via Zoom, and consent was taken remotely.

Staff volunteers for interviews were recruited using the following methods:

- Adverts in Staff news and on the Solent Team Facebook page.
- Emails from managers and team leads.
- Evaluation leads attended training and feedback events and invited delegates to follow up with more in-depth interviews.

Patient volunteers were recruited via:

- word of mouth (from teams and services) and personal invitations.
- by leaving their names at the ends of surveys when asked if they'd like to be able to give more information,
- via peers (for peer interviews).

Interview schedules

Interviews were carried out primarily over the phone, but occasionally in person. They were typically carried out by two people: one to ask questions and prompts, and the other to take notes. Generally, interviews lasted between 20 and 90 minutes.

A short interview guide was developed, to help interviewers, but the aim was not to script an interview but rather to let participants share their experience. These were typically not fully transcribed but notes taken, and key quotes captured; this was for speed and pragmatism.

Appreciative Inquiry

Our Appreciative Inquiry (AI) approach was still based on interviews, but with a stronger focus on what worked well, and what was learned (the other interviews were more focussed on experience).

AI was done with key groups around the organisation, including: Infection Prevention, IT, Emergency Planning, Occupational Health and some front-line teams.

Observations / Ethnography

From the beginning of lock down through to the workshops on recovery and reset, both evaluation leads attended a range of events to 'get a feel for the room' and to listen to the conversations. It also served as a relationship building exercise and a demonstration of a willingness to be a small part of the world that patient facing teams were living.

It also afforded some ethnographic and observational data and allowed for changes over time to be captured (for example, with those redeployed onto Southampton wards, we observed and took part in the induction day, later training days and carried out follow-up interviews when staff returned to their normal place of work).

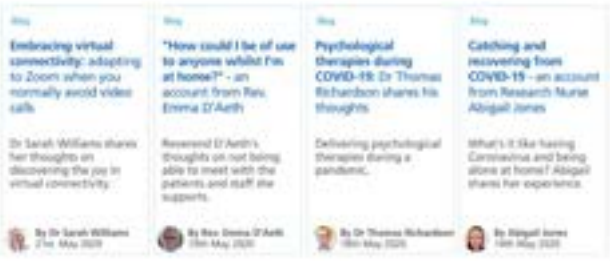
Events that were observed included:

- training and up-skilling of new/redeployed staff,
- launch of the new ward units at the beginning of the pandemic,
- learning and reflection events and,
- 'focus forums' for each service line.

Blogs: Our people, their stories

Calls for individuals to write their own accounts of their pandemic experience went out in staff news emails and on social media. Key teams and individuals were personally approached.

These were published on the Academy website and Trust intranet. The content was used as part of the evaluation narrative data.



Our services, their stories

We're sharing the experiences of our teams and services through 'Our services, their stories'. These aimed to capture their story as a team and how they had adapted and offered support either to staff or to patients.

They were published to support shared learning across and beyond the organisation. In some cases the 'resources' developed were shared nationally via the NHS Academy of Fab Stuff.

Spotlights were written on our Estates Team, Infection Prevention Control, the practice educators, Learning Disability, and a range of other front-line teams.

Surveys

Two core surveys were run for both patients and staff:

1 The experience of remote consultations

Between May and August two surveys were carried out using SurveyMonkey. One survey was targeted at staff and participants were encouraged to share how they were finding consultations either over the phone or via video calls. Patients received a similar survey on the experience and effectiveness of having consultations remotely. Most received this automatically at the end of a video consultation; some were sent it manually at the end of the appointment.

	Number of responses
Clinician experience of remote consultation	343
Patient/carer experience of remote consultation	464
Total	**807**

2 The experience of the lockdown period

An online experience-based design questionnaire was used to ask people how they had felt during the lockdown period; respondents were asked to choose words that expressed how they felt (both positive and more challenging emotions) at various stages - before, during and looking forward.

They were then invited to explain the reasons for their answers. This survey went out to both staff and patients between the middle of May and the middle of June. It was timed to go out at the point of that it looked likely that lockdown would be eased.

	Number of responses
Experience of working during the pandemic (Solent staff)	349
Experience of using our services during the pandemic (patients and service users)	100
Total	**449**

Timelines and events

A timeline of national and local events was mapped so that all findings from the interviews and surveys could be contextualised according to what was happening at the time.

We also summarised changes to services and the time at which they took place.

Quantitative data was taken from standard trust systems on the use of remote consultations, attendance at appointments and incident reporting.

Data Coding and analysis

The coding and analysis was done in three main stages:

1. The first coding team was separate to the data analysis and collection team. Two of our clinical academics worked through all the interview data and pulled out core themes. These were academics with qualitative research analysis training.
2. This was then "sense checked" for validity with themes highlighted by the data collection team who were asked to read through and note if the 'tone' of the themes felt right to them.
3. The final and full coding frame was pulled together by the two project leads. This was done individually and then cross checked and merged where necessary.

As a final reliability and validity measure, we worked alongside our mentor team at University College London who included Solent in their Rapid Evaluation. We were their only community organisation and they interviewed an additional 20 people, using a similar methodology. This was intended to give an independent set of interviewers and analysis. The themes that they have identified cross-matched very closely with those determined by our in-house analysis.

Dissemination and feedback

Dissemination will be done via social media, the Academy website and via formal reports to the Board. It is hoped that most of the findings can be displayed visually.

There will be a Trust feedback event in early 2021.

Tools we've used

Learning and evaluating at speed

COVID-19 meant a rapid change to the way in which we deliver healthcare services, and the way in which we all work together at the Trust. We wanted to capture this story, and to learn from what happened; how people felt, how patients found our new ways of working, what was working well or not so well.

In April 2020, we started our data collection. We decided to use "Rapid Evaluation Approaches" combined with Appreciative Inquiry. Rapid Evaluation let us gather learning at pace, using a range of methods summarised in the infographic below. We were extremely lucky to have the mentor-ship of from experts at the Rapid Research Evaluation and Appraisal Lab at UCL.

In numbers

the story so far...

What does an Academy do during a pandemic?

Research

Research is hugely important to us and we have consistently been named as the most research active Care Trust in England by the NIHR. With the pandemic, the research effort turned to rapid discovery of effective treatment and prevention of COVID-19. We've ensured that we are ready to support any trials and currently have a number of studies open. In addition, our research team is also supporting the national vaccine research programme.

Where we can, we've opened up more of the non COVID studies that had to pause.

The long-term impact on research is going to be significant

- **SIREN** - this study looks at infection and immunity levels of COVID-19 amongst healthcare professionals. We have 77 members of staff currently being tested.
- **COVID-19: ISARIC** - this study collates clinical data from patients who are on our inpatient wards with Coronavirus.
- **Psychological impact of COVID-19** - this survey aims to help us understand the psychological impact of Coronavirus.

Because of COVID-19, the visibility and importance of research has increased exponentially, and we will do whatever we can to help and support our staff and patients to be a big part of this.

Improvement

Our improvement work includes our audit and evaluation activity, and our **Quality Improvement Programme**.
It involves a lot of work supporting our staff as they carry out projects and a wide range of training events. Our training programme has now restarted and is being delivered virtually.

Our team has also been:

- Sourcing and distributing new
- Delivering online Quality Improvement
- Supporting teams to run in-depth

clinical guidelines for the management of Covid-19 and other conditions during this period.

Training and other workshops.

evaluations on new ways of working.

Patient and People Participation

Our face-to-face work has obviously temporarily stopped, but we're trying to stay in contact with the members of our **Side-by-Side network** and people from across our community.

Staying Connected Newsletter
This is published every two weeks and focuses on keeping our community up-to-date on what's happening, how they can get involved and where to find support.

Peer Interviews
Some of our Side-by-Side network member have been conducting peer interviews with patients across our services.

Zoom Conversations
We've been holding regular Zoom calls with patients and community members so that we can work with them as we reopen our services.

Our People, Their Stories
We've been exploring different ways to share the experience and stories of people in our community through a series of blogs and video diaries.

Involvement Toolkit
We've produced a selection of resources to support services to work in partnership with the people who use their services on planning.

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Learning

In addition to the above, our core purpose is to support learning and innovation. This is a critical time to remember to evaluate what we are doing, to constantly asses evidence and to provide support and guidance to clinical teams.

In addition to the **Solent Covid Evaluation and Learning** project we have also been supporting learning in the following ways:

Evidence reviews

We have been supporting rapid evidence reviews to help some of the decision making related to how we deliver services, including how to best look after Covid-positive patients at home. We would like to offer patients more choice about where they are looked after, especially if a hospital environment is possibly not in their best interest.

Good ideas and case studies

We are collating a series of case studies and examples of situations where things went well, from across the trust. These will be shared in a dedicated online space and we will also use social media and other channels to try to make this content easy to navigate and engage with.

Learning from excellence

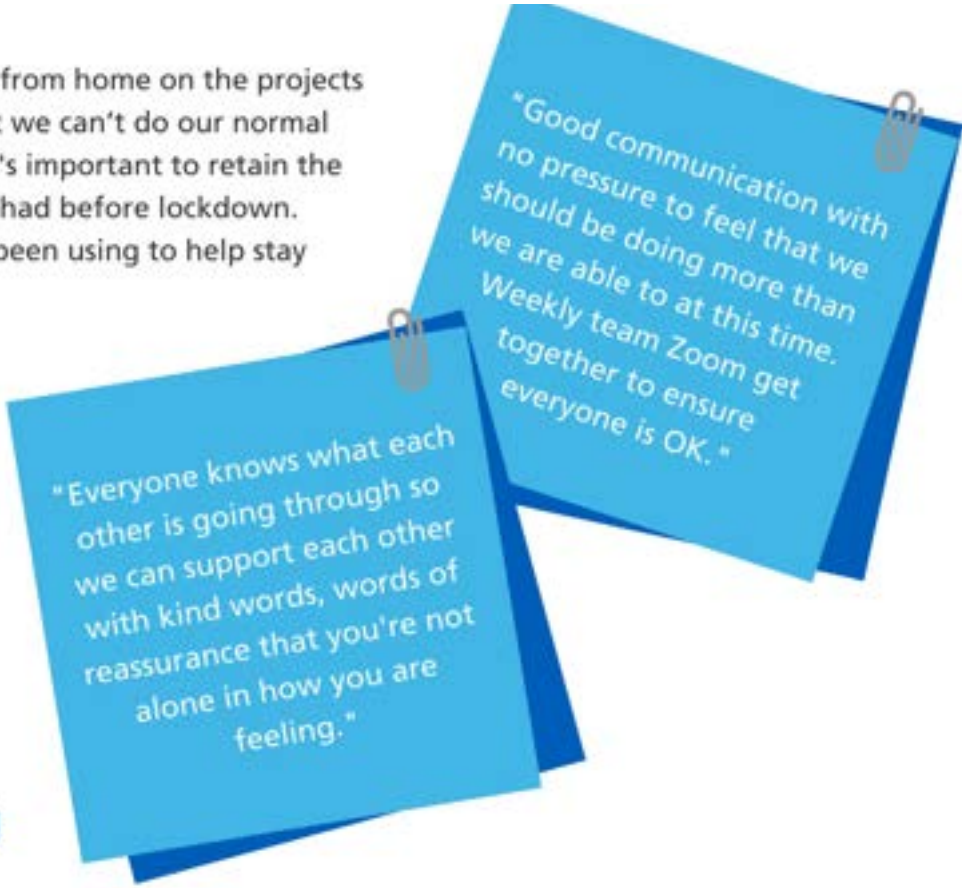
As keen members of the **Learning from Excellence** community we recognise that we learn much more from what goes right or well, than from what goes wrong. With this in mind, we are using a variety of methods to capture all of the good work that people and teams are doing, so that we can share the learning from this, spread good practice, and most importantly, say thank you and well done.
In addition to our online reporting system, we have produced an appreciation postcard and distributed these to our frontline teams.

Our team...

As with many teams across the NHS, we are working very differently. Many of our team members were redeployed in to different roles; working in clinical areas, supporting swabbing/testing for Coronavirus, providing administrative support for the supply of Personal Protective Equipment (PPE) distribution, and supporting the Infection Prevention team. We've been **sharing their stories and experiences on our blogs**, so go and take a look at what they've been up to.

Many of the team are working from home on the projects we've mentioned above. Whilst we can't do our normal activities as a team, we know it's important to retain the sense of a work family that we had before lockdown. Some of the things that we've been using to help stay connected are:

- a team WhatsApp group,
- Microsoft Teams, and
- regular Zoom meetings.



We send all our best wishes to you wherever you are, and hope you are doing okay.
Whilst we can't work the way we used to at the moment, we still look forward to hearing from you so do get in touch: involvement@solent.nhs.uk

COVID-19 Rapid Evaluation overview of findings

Sharing our findings

It's hard to convey the significance of the COVID-19 (Coronavirus) pandemic. For the NHS the changes were rapid, substantial and continual. Some services were paused, some continued with significant changes and new services were created; all of these changes happened almost overnight. At it's core the changes that were made were about people; the wards set up overnight, the extra hours worked by teams, the people suddenly faced with working alone from home, those who carried on caring whilst facing the unknown and of course, to the people we do it for - those within our care.

Our COVID-19 Rapid Evaluation was about capturing and learning from those changes by understanding the experience of those living through it.

As the repercussions of the pandemic continue to be felt across the NHS and its people, we hope that we've been able to capture and tell the Solent story so far. We also hope that these stories can inform how we adapt and change, how we work and how we deliver our care as we go forward.

Background to our evaluation
On 11th March 2020 The World Health Organisation (WHO) declared COVID-19 as a global pandemic. New self-isolation measures were announced by the Prime Minister (PM) as well as a stark message that "many more families are going to lose loved ones before their time". Images from an overwhelmed Italy filled the media, a country already in a nationwide lockdown and forewarning the dangers of a beleaguered healthcare system.

Following in Italy's footsteps, on the 16th March the UK PM announced that there would be a nationwide lockdown in order to reduce the spread and transmission of COVID-19. In the PM's first daily briefing it was announced that people should stop all non-essential contact with others and stop all unnecessary travel.

> We are asking people do something that is difficult and disruptive of their lives. And the right moment, as we've always said, is to do it when it is most effective, when we think it can make the biggest difference to slowing the spread of the disease, reducing the number of victims, reducing the number of fatalities.
>
> **- Boris Johnson, UK Prime Minister, 16th March 2020**

Solent had been preparing for a response to COVID-19 since January, when the virus first entered the UK, and the announcement on the 16th March 2020 marked a sudden and drastic change. For Solent, alongside every other health and social care provider in the UK, the announcement instigated the beginning of a rapid response in order to adapt to the changing needs of people within our care.

The importance of capturing the story of our response and of learning from it was clear; we set about planning a rapid evaluation, and started this in early April. The level of take up and engagement with the evaluation was a testament to the learning organisation that Solent has become. The summary of our findings are wide reaching, and come in many forms.

1. Compassionate leadership is central to people's experience of change

Clear and supportive leadership led to feelings of trust. Positive experiences of leadership was linked to good communication, transparency and compassion which generated a feeling of safety. Leadership that supported people's experiences often was from direct line-managers, but some line-managers reported difficulties in accessing their own support.

2. Connectedness with team and peers was key to helping people adapt to change

Sense of team and connectedness improved wellbeing and feelings of positivity; helping people as they adapt to change. Peer support decreased uncertainty, particularly for people in patient-facing roles as this contact helped to foster feelings of safety.

3. Everyone is different; people need individualised and personalised support

COVID-19 blurred the lines between our work lives and our home/family lives, and everyone's situation was different, with differing factors impacting them. People were able to adapt, respond and then thrive if they had leaders and peers who were able to respond compassionately to their specific, individual needs.

4. Change can be empowering but only in the right conditions

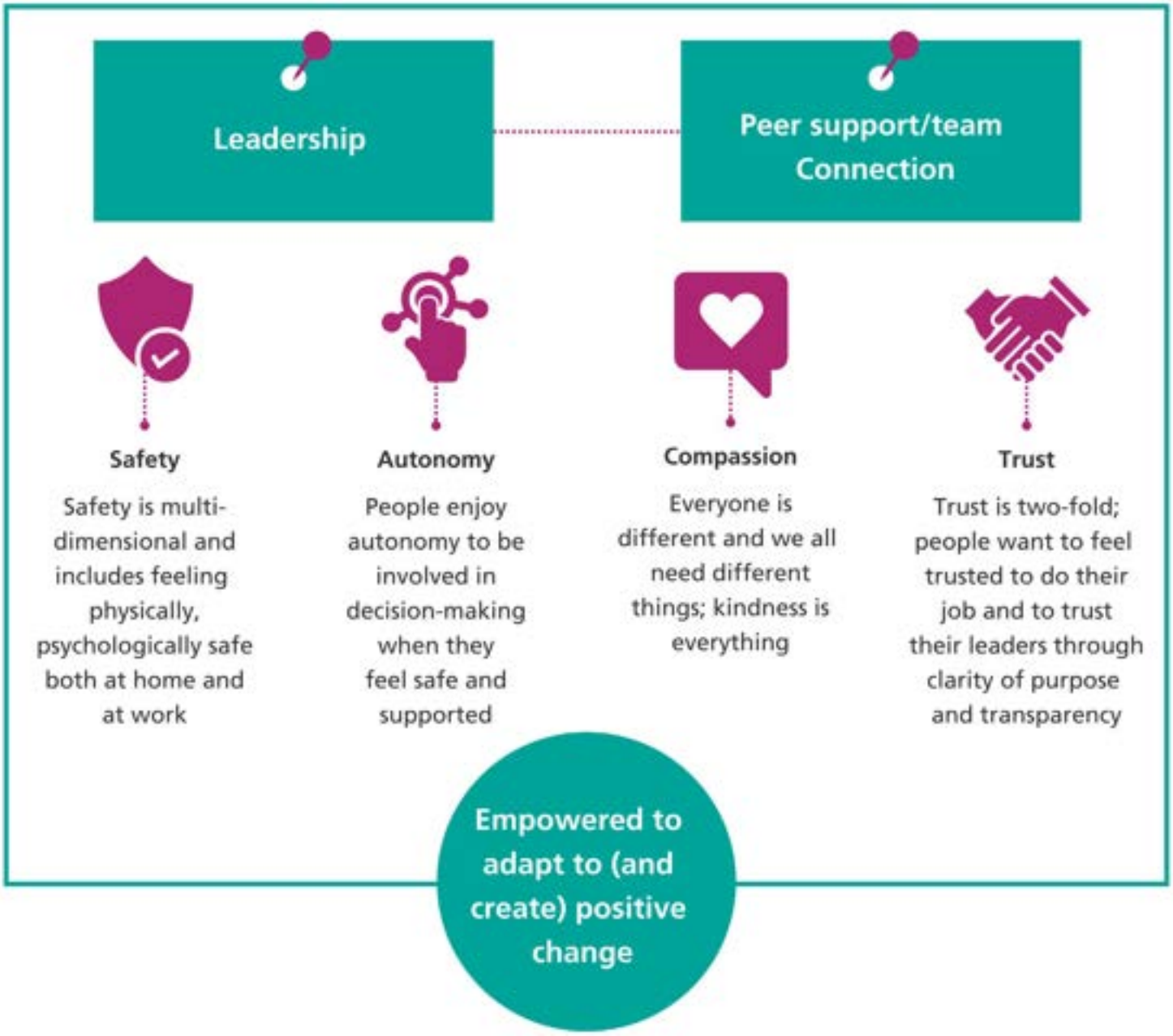
People with the right support not only adapted to change but were empowered to cultivate positive change. People who had both leadership and peer support were able to thrive and make positive change when underlined by the principles of autonomy, trust, safety and compassion.

5. The pandemic has facilitated a 'digital revolution'

The need to work from home and to carry out remote consultations with patients led to a rapid adoption of digital technologies. Often these were technologies or approaches that services had been trying to implement for a long time, but had been considered risky at the time. This has been shown to be a highly acceptable and effective approach both from the staff and patient viewpoint.

Our evaluation suggested that people need a 'Community of Support' that comes from both leadership and team peers, and is based on four key principles; safety, autonomy, trust and compassion. With these well established, front-line teams and individuals felt empowered to adapt and find innovative and positive solutions to the many challenges they faced. This will apply well beyond the pandemic.

Community of support



Our services, their stories

Learning in action

During COVID-19 our teams have been rapidly analysing the changes that they have had to make within their services. Within this section we will be sharing with you a selection of their findings.

Case Study: Portsmouth Learning Disability Service

Portsmouth Learning Disability Service:

responding and adapting to COVID-19

The Portsmouth Integrated Learning Disability (LD) service is a team of specialist clinicians who work in partnership with social care colleagues from Portsmouth City Council and service users, in order to deliver tailored support to people with learning disabilities.

With the outbreak of Coronavirus, not only did the team have to quickly adapt in order to still be able to provide their services, but they also had to implement a number of additional supportive systems for the people they were looking after.

Their aim...

In the early stages of COVID-19 the team rapidly developed user-friendly materials that explained what was changing in the service, and how people could continue to access support. They also implemented a co-ordinated approach to working with providers of residential and supported living, as well as a Red/Amber/Green (RAG) rating system that was used to assess individuals who were considered 'in urgent need of support.'

Higher levels of engagement with their services has been associated with better healthcare and wellbeing, in part because difficulty maintaining a normal routine can lead to increased anxiety and worry for service users. This meant that adapting to an online support structure, combined with embracing digital innovations to increase engagement was crucial.

Notification cards

They designed 'notification cards' that people with learning disabilities could carry with them whilst they were out of their homes, to show to the police if they were stopped.

In addition, they also wrote letters for carers or staff to use if they need to be out with service users for longer than the specified length of time, for example, those with autism were allowed extended time outside during lockdown.

Dedicated Facebook group

A closed/private facebook group was established to provide service users, their family members and carers with a safe space to share information and resources, as well as fun activities to maintain engagement at home.

This has been a really important way of maintaining contact and connectedness with their service users, and the team have been able to send out useful advice about things such as sleep hygiene and hand washing. Service users have also been sharing pictures of what they are doing to pass the time, and are offering each other moral support and advice. Those in the group seem to really value this safe online space, and it has received great positive feedback.

Pinterest ideas

Recognising the need to provide service users with ways to stay active whilst at home, the Occupational Therapy team at the Kestrel Centre created a Pinterest page to share ideas for individuals to try out.

They set up specific boards for people with mild, moderate, profound and multiple learning difficulties, and added suitable activities, crafts and cooking ideas to each board.

Take a look at their Pinterest boards...

Activity and schedule

It's important for service users to keep daily or weekly plans in order to maintain a sense of structure and normality. With this in mind, the team created a schedule containing a mixture of BACE activities:

Body care - maintaining physical and mental wellbeing, such as: having a shower, eating a meal and doing some breathing exercises

Achieve - things that give a sense of achievement and purpose, such as: playing a game, learning a new skill or creating something (eg, a film, painting or poem)

Connect - understanding the importance of interacting with others, this type of activity focuses on staying connected with letters, emails and telephone calls

Energy - taking pleasure in leisure tasks, such as: reading a book, tie-dying a t-shirt, taking a bath or making a scrap book

Autonome

Enabling service users to be independent and safely complete activities at home during lockdown was really important, so the team introduced the Autonome App.

The app has over 100 videos on it, and helps vulnerable people as they develop skills by keeping track of their progress and setting reminders and providing support whenever they need it.

Video calling

Encouraging service users to engage with video phone calling such as FaceTime and Skype, to provide virtual-face-to-face interaction.

Apps

Introducing Apps to enhance service user's day-to-day lives, such as:

Drink Water Reminder N Tracker - reminds you to drink enough water

Pillboxie - an app to help you remember to take your medication

Dental Hygiene Mastery - helps you understand about dental hygiene

Messages

Using messages with minimal text and supporting images to help service users understand what to do if they think they may have COVID-19:

Social story

The team also put together an accessible story to help explain what COVID-19 is, what happens if people get it and the impact on the services they use in a really user-friendly format.

Spotlight on Redeployment

Our learning

In response to the anticipation of the first wave of the COVID-19 pandemic, many Solent NHS Trust staff members were asked to step out of their "normal" roles and support other services in order to address the changing needs of our teams.

> We have Allied Health Professionals [AHPs] who have worked as AHPs always and we told the redeployment team you can use us but they didn't listen, it felt like no one heard us – instead they [AHPs] were redeployed as HCAs and it didn't work as well as they would have liked, they are OTs [Occupational Therapists] and Physios and trained as therapists, so they perhaps missed their expertise

New skills and new relationships; the "take homes" from redeployment

- People's positive experiences of redeployment were linked to learning new skills which could be used in their role in a different way, as well as developing relationships with other teams and services.
- This contributed to a sense of pride and sense of being part of a consolidated team.
- For some, this sense of team was also echoed when people returned from redeployment to their own teams, particularly when they hadn't enjoyed redeployment.
- Lots of people were very positive about the training and the opportunity to advance their skillset.
- For some, there was a difference in what was learnt in training and clinical practice, although frustrating most people were able to overcome this with support from their new team.
- Redeployment allowed for greater understanding of different roles.

> I met some superb people and have made friends for life. I also couldn't have asked for better training. I know so much more now.

> The outcome is that the relationships between ward, therapy and community staff has really improved.

> I enjoyed learning new things – I enjoyed having to think on my feet and apply my own common sense.

> There is now a sense of readiness and having gained so many new skills.

Communication and connection

Communication in the early days around redeployment was confused (different surveys, little follow up).

There were long delays between being asked or told about redeployment and anything happening.

People wanted to be kept informed even if there was little to report.

Loss of contact with team members was isolating to begin with.

Keeping in touch with the team they came from help to support those who were redeployed, and kept them connected.

> Clearer guidance would have been helpful.... clearer steps and more communication to those that are being redeployed and awaiting information.

> Things felt muddled, duplicated and frustrating. People were trying to be helpful and firing things off but this caused confusion.

> Getting an email to tell me I was redeploying but not having any details of the job, or who I would be working with – the department wasn't even expecting us which made us feel we were in the way.

> I felt I wasn't having much contact with colleagues as I was working in [different] clinics – this impacted as it was much harder to access support for well-being

Learning for improvement

Increased support for sources of uncertainty around changing roles.

Increased communication about processes and next steps.

Personalise redeployment; decisions are multi-dimensional and should consider the individual.

Increased autonomy for people to have say about redeployment.

Improved planning for demand for care and need for staff.

Learning from excellence; keeping the good things

Up-skilling and training – people found increased confidence from sessions and enjoyed sessions as a source of peer support.

Peer led learning - many people enjoyed stepping into different areas, thereby understanding people's roles increasing relationships between teams and services.

Professional identity and skills – people who were able to keep their professional identity and use skills that they already had had a more positive experience.

Key learning take-aways; what you need to know

If redeployment is needed managers should have early discussions with team members to understand people's preferences and skills. This decision should be holistic taking into consideration the person, work, family and home.

Keep people informed - even if there is no news, let them know that.

Focus on a values based approach, ie what do people prefer, how would people's skills best be used?

This should match rosters – allowing people to have notice on what shifts they will be doing, so they can balance family requirements.

Where possible keep people in roles that match their professional identity.

Ensure that staff have a mixture of leadership and peer support with their original team and their new team.

Ensure a team vision – everyone has a role to play, value every contribution whether redeployed or remaining in current role.

If you have people redeployed to your area encourage a peer led buddy system for pastoral support and clinical support.

Spotlight on Working From Home

Our learning

In response to UK Government Guidance, Solent staff have been asked to work from home where possible. This section describes what we heard from people working in Solent about their experience about this new way of working. The majority of the data collection took place between April and August but the learning includes feedback received until December 2020.

Key events from 2020 so far:

- **17th March** - Solent announce that 'following the change in government advice, we have sent messages to your leadership teams with advice on working from home. Our aim is for as many people to work at home as possible.'
- **23rd March** - Occupational Health and Wellbeing launch guidance on how to stay healthy and get the most out of working from home.
- **30th March** - Daily employee Zoom calls launched.
- **12th May** - Solent staff encouraged to work from home if they are able to do so. Additional support offered to people who are working and parenting from home.
- **5th June** - Additional guidance offered for taking care of 'bones, joints and muscles (MSK) whilst working from home.
- **11th June** - Solent creates 'working from home' self-checklist.
- **20th July** - Solent announces COVID-19 secure guidelines.
- **23rd September** - Change in government guidance; people, who can effectively work from home, should do.
- **5th November** - Second UK National Lockdown; 'we expect as many people work from home as possible'.

Data sources

1. Interviews with those working at home.
2. Experience based design survey data (emotional mapping).
3. Survey feedback from staff carrying out remote consultations from home.
4. Ethnographic notes – from dedicated zoom calls on working from home, isolation

Key themes

Blurred boundaries between home and work

Physical and psychological wellbeing

Connection and team "togetherness"

Autonomous working

Rapid Learning; Cultural Revolution

Blurred boundaries between home and work

- The ability to separate home life and work life is much more challenging when working from home.
- Many people have children at home, as well as partners also working within the house.
- The added responsibility of childcare and home schooling was a source of significant stress. Those who are able to flex their working hours to adjust to family demands find this useful.
- The inability to visit or connect with family, and concerns about their wellbeing can't be separated from a daily work life. The dangers from the pandemic are omnipresent.
- For a significant number, people's experiences are mediated by type of work and environment:

Type of work - in many instances people who were carrying out remote consultations and clinical work from home found working this way far more challenging.

Environment - the availability of dedicated space to work in was a challenge. Many were working in kitchens or bedrooms, with no access to quiet space; this raised concerns about professionalism and confidentiality.

Normal place of work - some people who would normally have been front-line had to change roles and work from home because they were shielding, or in high risk categories. Often their colleagues were still visiting patients or working on wards and in clinics, this increased feelings of guilt and isolation.

> When we are all stuck in our homes, there is no separation between the place you go to discuss your worries in detail, and the place you try to relax and watch TV in the evening.

> I still have noisy kids around and I don't have my own office space. I can hear the kids in the background and they still come in and ask me questions. I have found it very distracting and at

> It messes with normal living as you never know what will happen. This is difficult for things such as planning meals or child care – some kids have become quite unsettled.

> This is hard in your own home - those emotions and that trauma are in your home. There are blurred lines between home and work.

times, felt unprofessional.

> I had to work from home because of my own health, I felt I was a let down of a nurse, I felt useless for a while.

> I sit all day on my bed, go down for tea, have a shower etc...then back to the bedroom to get into bed. I have struggled with that, and I still do.

Physical and psychological wellbeing

For many, working from home has many advantages - some enjoy not having to commute or spend a lot of time travelling.

Many found the greater flexibility stimulating, and as a result, productivity increased.

The physical set up, however, was often not ideal; with poor seating, working positions and lighting leading to some back and neck pain. Staff were working on beds, on ironing boards or balancing laptops on their laps.

Whilst the rapid roll out of IT functionality enabled safety and at home working, the frustration that came from having to quickly learn a lot of new technology and struggling with connectivity was a challenge for many.

Respondents also reported some isolation and loneliness from being at home, which was emotionally challenging.

Some also felt that their psychological safety was threatened by having to 'allow patients into my house'. The lack of a professional environment limited the psychological distance from patients, which sometimes felt intrusive.

As time went on, some techniques to help with this were put in place. For example, people could collect screens and furniture to borrow to make their workplace set up more suitable.

> As time went on, I felt work took over more and more, and the work and home life became very blurred.

> If your last call of the day is a horrible one...they are rude to you or whatever... you've got that....you're just at home, there's no drive home, there's no talk to your colleague. It's really difficult.

> I have phone calls with patients that I wouldn't want to have at home, especially with my son around at the time e.g. those with suicidal thoughts. I feel like I come across as being not genuine to the person because they can hear children in the background.

> What I have found really difficult is separating my work and home life. I had one really difficult call with a guy I have been working with and he was getting really angry over the phone. Afterwards I felt really annoyed as it was my personal space being invaded.

> This is hard in your own home as then those emotions and that trauma are in your homes. There are blurred lines between home and work.

People learned to be more "boundaried" about their work and 'clock off' on time. Or take a walk in the day - some actually had a short walk in the morning and evening to simulate the going to and from work.

Psychological support such as increased supervision, daily check-ins and virtual coffee breaks were introduced in some teams.

> Not leaving my house to go to work is a change in itself. I've worked for the NHS since I was 18 so I'm very used to the routine, now I just come down the stairs and I'm at work. It was tricky at first, I had to learn to have boundaries; to clock on and off, like I would in the office.

Connection and team "togetherness"

One of the key challenges to working from home was the loss of the daily connection with colleagues and the team.

The casual conversations that were either social or professional were a mainstay of most people's professional experience, and that suddenly was unavailable.

This was extremely daunting for many, particularly when dealing with more complex patients, or for more junior and less experienced clinicians.

The ability to feel connected to and part of one's team was one of the most important elements to wellbeing as the pandemic progressed.

There is a risk of a 'them and us' culture developing as some can work from home and others cannot.

> For me the most challenging thing about it was missing my work colleagues. That has been the hardest part and I have not seen them since March which is tough. Recently a photo of our team was sent out for National Nurses Day, which was emotional seeing their faces.

> Support from colleagues has been really good but I have noticed that the time away from work and not being able to access that easy support network has been difficult for me.

> The loss of the support network and people who know you well and who can tell when things aren't okay

> It was different on Zoom or whatever because after a difficult session, the patient is essentially in my home so when physically at work you're able to leave the room, have a cup of tea, talk to colleagues and other distractions; at home it's much more difficult with less distractions.

Autonomous working; trust vs. risk

People spoke positively of having the option of working from home, enjoying the flexibility.

Some people spoke of a need for a changed perception towards working from home particularly around the concept of trust. Many reported early on in lockdown being worried about being trusted to work productively at home (managers had previously not allowed it) and felt the need to work longer hours to increase and "prove" productivity.

Over time, working at home and flexibility has felt more acceptable and normalised.

Along with the enjoyed increased autonomy, this was a 'bit scary' for some staff who felt that they needed more support from colleagues when talking to patients.

> The definite positive for me has been being able to work from home. I think I work quite well from home and I am much more productive.

> Initially undecided whether I liked working from home but not having the commute is beneficial. I'm getting more sleep, having a proper lunch and taking the dog for a walk. I've found my flow.

> In team meetings on Zoom my manager would say things like "XX can do that - she's working from home", without considering my view, as if I was doing nothing or had all the time in the world.

Rapid Learning; a cultural revolution (you're on mute)

The transition to working from home or working differently happened very rapidly and with little ability to advance plan.

It took place in a time of heightened national and personal anxiety and uncertainty.

Teams and individuals had to adapt rapidly to a very different working environment.

The most obvious new skillsets required were IT related - how to use video conferencing, how to use MS Teams, how to use any remote consultation software and for some, how to access systems from home. For many, this required rapid learning equating to new languages, for many, IT literacy and general technological understanding wasn't well developed.

The cultural shift to enable this to happen is significant - and the adaptation has been impressive. Attention is still required to individual needs around training, support, and to the human factors around change.

They also had to learn news skills and adapt to new ways of working almost overnight.

From clinical consultations to team meetings, all the way up to Trust Board meetings, the business of the organisation has shifted to a virtual environment over the course of just a few months.

People have had to learn new ways of communicating with teams and patients, and a new set of 'perceived risks' around the quality of care for patients.

My mind shifts between feeling positive and excited about integrating a lot of what we have learned, and developing new ways of working, but this is a vastly steep learning curve with many unknowns which can feel overwhelming at times.

Feels like the NHS is in a period of 're-set' for example moving to use virtual consultations and appointments. No waffle, things just get done and implemented quickly. When forced into rolling things out or making changes, it has gone really well.

Hugely happy and I have to ask myself "why haven't we done this years ago?" I guess the answer would be lack of time, sometimes it takes something drastic to make things happen that you've thought about for years.

We have embraced the digital revolution!

Learning for improvement

During the early days of the pandemic, many people had to work from home and the adaptation was stressful for many. It was clear that a personalised level of support was necessary, given individual circumstances around family, health and the teams within which they worked.

Those working at home all the time as they were unable to come to their base often felt more isolated and vulnerable, particularly when their team was working front line.

When all or part of teams are working at home, there is a need to pay particular attention to team connection both professionally and for social reasons.

There needs to be a level of flexibility around need - not everyone enjoys a team quiz. Some people want more communication others will need less.

People who are working clinically at home will need additional support in terms of holding risk and psychological wellbeing.

Where home working is likely to be ongoing, workspace environment support is needed.

Learning from excellence

The rapid decision to allow and encourage people to work from home contributed to a feeling of being valued and cared for.

The rapid deployment of IT and equipment enabled the vast majority of people to work at home effectively within a very short time, and to continue to feel productive in their role. It also enabled ongoing connection with patients.

There was a period of rapid learning and a cultural/technical revolution as new practices became the norm

The acceptability of flexible home working has increased substantially.

Many new forms of communication between teams have been established to address feelings of isolation, such as virtual coffee mornings, evening social events for teams, regular check-ins and enhanced supervision.

Over time, people have adapted to working from home well, although there are still many challenges around team connection and infrastructure (workspace set up, connectivity etc).

Key learning take-aways; what you need to know

- There has been a significant cultural shift in the acceptability and ability to work effectively from home
- Most people in Solent have coped with rapid learning and adaption to digital technologies. However, there is an ongoing need for training and support around IT literacy, and easy support around connectivity.
- Many people enjoy working at home, or having the option for flexibility – the ability to fit in family demands and not spend many hours travelling has improved work-life balance
- Consideration of 'safe' space at home for working is important, particularly with vulnerable clients. Many clinicians felt that their psychological safety was often compromised by letting patients into their home. In some situations, increased clinical supervision may be beneficial
- The ability to feel connected to the Trust and to a team is critical.

Spotlight on Remote Consultations

Data sources

1. Project documents from the ICT team.
2. Clinical record summary data on consultation type.
3. Surveys on the experience of use (375 staff and 495 patient respondents).
4. Interviews with patients and staff.

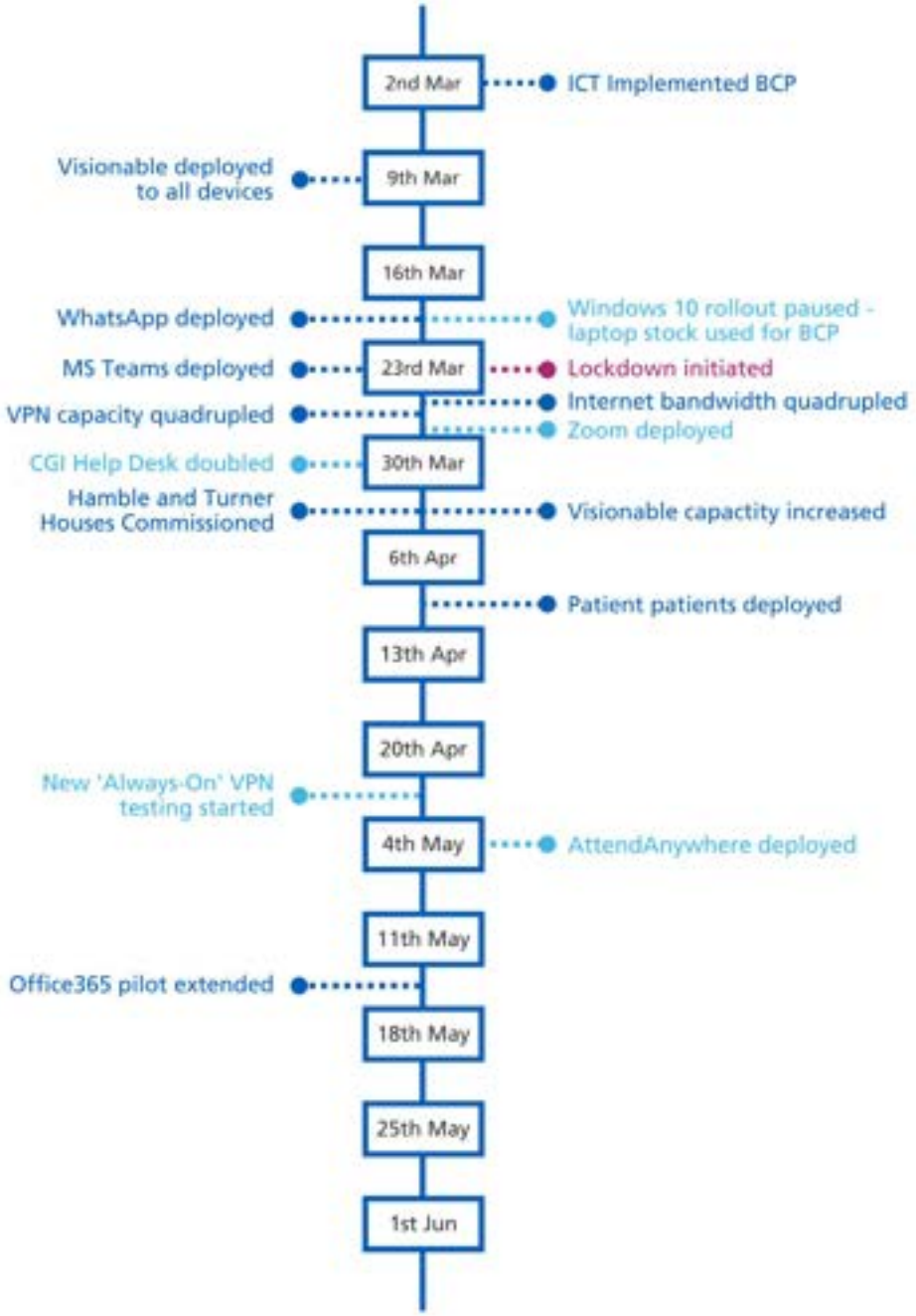
What happened in Solent?

Prior to COVID-19, Solent NHS Trust was undertaking an ambitious programme of digital transformation.

With the onset of the pandemic, it was clear that a large proportion of our workforce would have to work either from home or in different locations.

Solent ICT team rapidly mobilised a programme of equipment and software roll-out, and established connectivity in a number of new sites across Hampshire. Access to platforms such as Zoom and WhatsApp was approved, and additional video consultation software was made available, starting with Visionable, and then, AttendAnywhere after a few weeks).

This infrastructure enabled remote consultations with patients, even if clinicians were working at home. Patients could be contacted via a phone system or video link.



Rapid move to remote consultation

Face-to-face physical contacts dropped by approximately 50-75% at the end of March when lockdown came into force. Contacts fell to approximately 10,000 a week, then stabilised towards May at about 12,500 a week - this didn't change much between May and August.

Telephone consultations quadrupled from 500 to 2000 a week, over the course of March.

Video consultations saw a rapid and sharp increase as lockdown occurred from less than 10 to over 500 a week. The primary platforms used were Visionable, AttendAnywhere and Zoom.

Context

- 60% of clinicians were conducting remote consultations from home, 30% from their normal place of work.
- Of those working at home, 60% were using their home broadband rather than the Vodaphone SIM.

Connectivity

There have been challenges with connectivity.

The responses from the survey data showed over 60% of the calls were reported as easy to connect to and successful.

A further 25% were reported to be relatively easy to get into but there were challenges with calls freezing or cutting off.

Very few reported severe connection issues.

There were some difficulties with a 'lag' or with delays with the video:

> We could connect but there was always a 2 -3 second lag between audio and video.

> The sync was out so we kept talking over each other.

Some experienced challenges with the technology - training or information leaflets would be of benefit. Patients sometimes had to ask relatives to assist them.

> The patient was on their iPhone and to get them connected they had to ask their daughter to help set up.

Effectiveness of the consultation

- It is clear that remote/video consultations are an acceptable method of communication for most clinicians and could be used in combination with face-to-face sessions.
- 60% were concerned that remote consultations weren't as effective as a face-to-face session, but worked well enough given the circumstances.
- 20% of respondents thought there were either as effective or better than face-to-face.
- 96% said they would be happy to use remote consultations in some form post pandemic.
- The needs of the individual patient are important in the type of consultation

What's missing?

A move to remote consultation is by no means a 'lift and shift' exercise, it is a unique type of communication between clinician and patient.

Elements of a traditional consultation that presented challenges were:

- Not being able to do full assessments
- Lacking non verbal cues
- Missing the 'sense in the room'; "It's like two of our senses have been stripped away"
- Patients being so grateful for the call, that they don't reveal all of the issues
- Not having all diagnostic tests available

> We've been providing a service to the best of our ability. But we're all feeling uncomfortable that we're not providing the service that we'd like to.

> I miss the luxury of face to face. It's ok over the phone but the rapport with the patient is slightly blurred. No patients are complaining at lack of face to face but I think it would be better.

> Missing a lot of non-verbal clues around mood, compliance. Plays a huge part in decision making.

Clinicians were also concerned that there was an impact on an ability to build good relationships with patients. Or to make a good human connection.

"I think that the rapport I have built up over the months with patients has been interrupted by this. Over the phone is just not the same as face to face contact.

"I wanted to hold her hand, I wanted to look in her eye when I told her diagnosis.

"The client became tearful at one point – it's harder to show compassion and give comfort/ support over the video.

"Remote consults miss the 'sense' you get about patients. It makes it so much harder to build trust and relationships.

"I worry in case we are missing something that may be easier to pick up F2F, eg .domestic violence issues. People tend to be more open if there is rapport already. The subtle signs/holding back the truth might be missed; a learning disability is not always obvious over the phone.

What is gained?

The environment

There were many situations in which there was a reported advantage to remote consultations, in particular 'seeing' patients in their own environment:

- understanding a child's home environment has helped therapists to understand a family more broadly and often a child is more relaxed at home,
- seeing patients practice exercises in their home enabled therapists to adjust accordingly, which wouldn't be possible in a clinic,
- additional materials could be provided online to support consultations.

"Parents have been able to record their children eating and drinking in a much more natural environment to what would normally occur when I do a home visit...it has allowed me an opportunity to get "inside" the home.

"[Video provides] a great insight in to [the child's] natural environment. It helped me to understand Mum and the wider home/family dynamics.

"Many multiagency meetings have been facilitated via video call, often with more professionals and agencies attending than would have been possible in a face-to-face meeting. This has significant

Inclusion

- Patients and families are now able to be included in in multidisciplinary or multi-agency meetings.
- Relationships with stakeholders have improved.
- The patients have increased access in some

meeting. This has significant benefits for families, being able to access multiagency support and information in one space.

- The patients have increased access in some ways, for example, reduced pain from travel (eg rheumatology patients).

Use of time

As clinicians adapted to remote consultations, they found that they were 'better' for many types of calls and they could make better use of their time.

> This was a review that I would have normally gone into school to complete however, I was able to see the child complete a couple of tasks and talk to mum about any other concerns. This then lead to discharge. Time-wise it was really useful; no travel to the school, talked to mum and didn't have to play telephone tennis with them. It was nice to round it up in one go as well being able to see parents and them to see me.

> One other positive example was an experience I had of a child being discharged from Southampton. It has always been extremely difficult to organise attendance of appropriate staff at MDTs. They were able to set up a remote MDT meeting on Zoom and this was fantastic. It was great to have everyone in the hospital, along with community therapists, a parent at the home and also a parent at the hospital. It worked so much better and it enabled staff to attend, as otherwise they would have had to take the time to drive over to Southampton when it was much easier for them to spare an hour on Zoom.

> One thing that surprised me was how many patients you can manage doing remote phone calls in both my job roles. You can manage less complex patients well with a telephone call.

> Less faffing around... more time engaging with the patient... that's got to be better value.

> I think the remote consults will help with waiting lists and may help with better assessments at speed, rather than always visiting people's homes.

Peer support - the importance of team

COVID has strongly highlighted the importance of team and peer support, particularly for clinical decision.

The 'quick question', or 'head around the door to check something' way of working was made very difficult for clinicians as most remote consultations happened from their home.

This increased autonomy came with a sense of increased risk for some.

Additional supervision and support measures have been implemented to try to counteract isolation, including daily check-ins, more supervision, buddy systems and closed WhatsApp or Facebook groups.

"You underestimate the support you get from your colleagues where you can quickly go into the next cubicle and speak to a colleague for another opinion about your patient. Personally I like to ask questions and to chat through a patient's condition so as to learn how to manage these things. You can still call people but it doesn't happen as easily as people are busy so this has become more difficult.

"What has been challenging is not having those ad-hoc conversations that you would usually have when something is playing on your mind.

"You ask yourself "am I taking too much of a risk here?" When you are in a face-to-face team you usually have colleagues around you or with you. There is immediate support. This isn't the same way when working alone at home.

"We were taking calls from people at real crisis level. It definitely helped having the psychologists alongside us on the calls.

"The change was especially difficult for those who are less experienced clinicians or are more risk adverse and they would normally be able to constantly check with colleagues and pull back the curtain to ask someone's advice. Now they are suddenly at home with no sense checking and no corridor consults. It is a big ask.

"It was down to our judgement, which was tricky at times.

Fatigue

The act of carrying out consultations remotely feels more tiring for clinicians. Many reported increased fatigue - both from increased concentration but also from worry about others.

> I have to work harder to pay attention to the cues that I can get, so I'm more exhausted after a clinic.

> It is much harder to read body language remotely. This is perhaps why, despite my commute shortening from 20 miles to one staircase, I am feeling really tired.

> Being out of the way and upstairs is much better, but it has been difficult to juggle with no childcare support. It has also been difficult to hold confidential conversations at home too.

> I don't want to have to shut my child in a bedroom while I make a phone call and it's hard for him to understand why. I can't concentrate properly.

Invasion of personal space

Where consultations were carried out from home, clinicians struggled to find adequate 'space' between work and home. For some this was challenging for confidentiality but also a sense of personal space and safety – a split between the emotive work environment and home.

How willing would you be to use remote consultation (either instead of, or alongside face-to-face appointments) in the future (n=488)?

Connection

The most common device used by patients for calls is a smartphone (45% overall, and 55% in those aged under 55), followed by either a laptop or tablet. Only 10% used a telephone.

76% used a link provided by the service and 17% used Zoom.

Very few reported having major problems connecting to the call; 76% reported that it was very easy, with a further 18% saying it 'was okay'. Only 5% reported having difficulty.

Acceptability

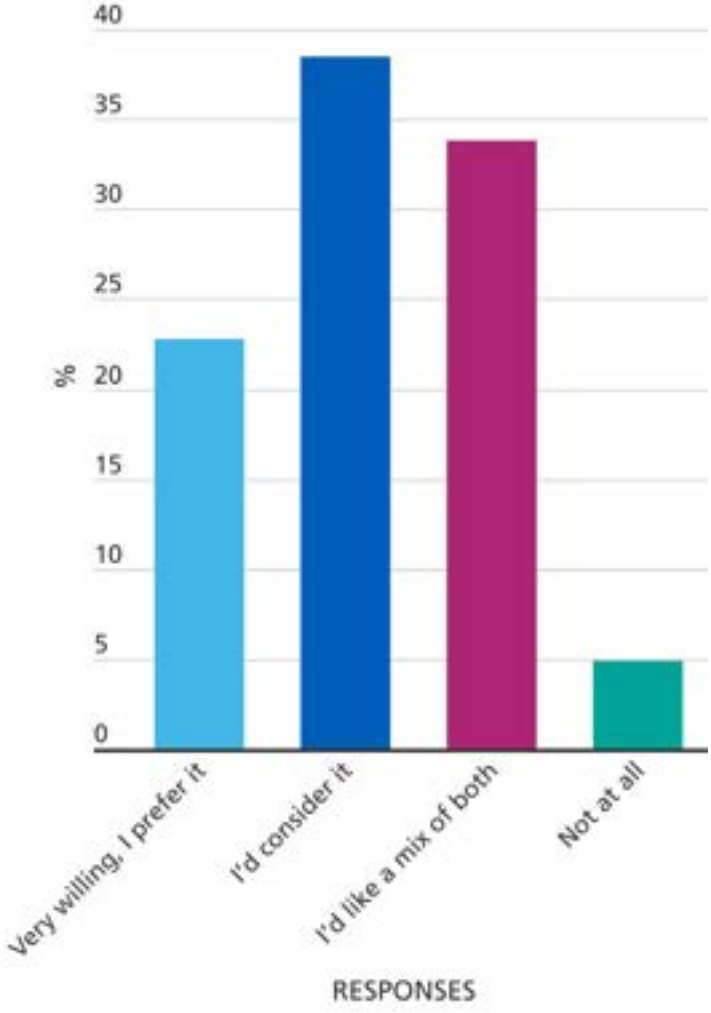
When asked about preference in comparison to face-to-face, respondents state the following about remote consultations:

Acceptability of this type of consultation is high - a third reported 'loving it' and another 43% 'liked it'. Only 4% reported not being happy about their experience.

Just over 10% said they preferred remote consultation, and 55% said they thought they were more or less the same. The remaining 30% said they preferred face-to-face but understood why a remote consultation was necessary.

Overall, 85% said that they were able to get all or most of what they needed to achieve during the consultation.

95% of respondents reported that they would be happy to have some degree of remote consultation going forward.



The benefits

Convenience

Comfort

Safety

Self care

Easy, and think of the time and money saved by not having to take time off work to drive to the surgery and sit and wait. This is the way forward I think.

Quick and simple.

Made it easier to arrange a time and logistics; it meant that M could run off and play whilst we went over more things.

The ease of being in my own home and not having to travel with a young child is very convenient.

Being in my own surroundings made me feel more at ease.

Very relaxing being able to be in my home environment.

Less hassle than going in in person.

The challenges

There were very few challenges reported, those issues that were mentioned centred on connectivity and communication.

The video screen froze making it tricky to see what the consultant was showing me.

The lag meant we were talking over each other.

He couldn't physically examine me so that diagnosis was likely limited.

Connection problems, screen freezing and the sound is poor.

Can be challenging to see what movements I'm doing.

Trying to show a dentist a child's back tooth isn't easy.

The exercises are sometimes difficult to understand – this is where a hands on approach might be better.

Just difficult for the nurse to see my stoma up close...I worry something could be missed as it's hard for her to see it.

It feels like patients are starting to take more responsibility for their own health.

Self-care is better and my time is saved if people are doing more self-care... that doesn't have to change after COVID...[I noticed] changing attitudes about risk and self-care... less ownership of other peoples feet... we cant afford to go backwards.. It's an opportunity to change how we work.

For patients it has made us give people responsibility for self-management, we've been giving people their own things to do and be responsible and then we monitor them. This is something that we've wanted to do for a long time and it has forced that issue forward which is good.

It's forced us to push forward with the self-management idea that we've had for a long time and not acted on, and it is going well for a lot of patients.

Acceptability

Before COVID, as an organisation, Solent was on an ambitious journey of digital transformation.

A number of factors made this challenging, not least the hesitancy of clinicians who were concerned about the impact on their care and how patients would perceive it.

COVID took this decision out of many people's hands, and enabled a revolution in the perception of different types of consultation.

Many reported how positive this felt, and that there was a chance to rethink many of the ways in which clinical interactions could take place.

From a professional point of view, exploring how we can do things remotely and have good therapeutic connection - perhaps (we should) offer more choice in the future as some people prefer to communicate remotely we have recently discovered.

We have been forced to think more creatively in our offer of support.

The current situation has forced us to innovate, an innovation I hope we will keep.

Feels like the NHS is in a period of 're-set' for example moving to use virtual consultations/ appointments. No waffle, things just get done and implemented quickly. When forced into rolling things out or making changes, it has gone really well.

Remote consultations have worked very well for lots of things and have given us an opportunity to rapidly pilot things we were hoping to start but we're struggling to get all the ducks lined up.

Hugely happy and I have to ask myself "why haven't we done this years ago?" I guess the answer would be lack of time, sometimes it takes something drastic to make things happen that you've thought about for years.

I would not have agreed with that change but now (reluctantly!)I agree that maybe 80% of work can be done by phone.

Consultations now done over the phone, it has been revolutionary; I can't believe we didn't do more of this before lockdown.

We historically tend to do practices a certain way because that's how they have always been done and it never gets looked at. Telephone consultations and chlamydia treatment by post has revolutionised that.

Liked that we have embraced the digital revolution! We want to keep them and develop them... WhatsApp and Zoom. We could use these lots as they meet the needs of our clients. Possibly more inclusive e.g. for teenagers.

As we get better I think for a lot of people it will be as good as a face to face consult if they are able to use it

Learning for improvement

Remote consultations are not ideal for all episodes of care, and the absence of non verbal cues, and the inability to do full physical examinations have an impact on care.

The technology or internet connections aren't yet stable enough. The 3G connection for home working doesn't work well enough for many, and so they use home broadband – the quality of connectivity is often limited.

Remote consultations require new clinical skills, and dedicated supervision. Many staff felt that they were holding additional risk that they were uncomfortable with.

Clinicians were worried about the quality of care that they were giving, and the possible impact on building relationships and rapport with patients. This was particularly problematic when delivering difficult news.

The remote consults felt more tiring for clinicians, many reporting being 'exhausted' at the end of the day.

If people are working at home, there are issues of feeling that personal space and privacy are compromised, and there is a lack of access for peer and colleague support.

The importance of team and the support of colleagues is particularly applicable where clinicians feel they are more isolated or are holding more risk.

Learning from excellence

Solent was able to rapidly enable remote consultations in a short time period, enabling people to work from home and continue to provide care.

Remote consultations are highly acceptable and successful for many types of consultations.

In some cases they improve access and the quality of the interaction. They have been used widely across the Trust, both for individuals and groups.

Innovative solutions such as providing additional online material to support consultations have helped improve the quality of remote consultations.

The ability to see patients or families in their home environments has led to an improved quality of care.

Remote consultation has enabled more effective multidisciplinary and agency working, allowed patients to attend and improved working relationships.

Over 95% of patients and clinicians would like to see remote consultations continued in some form.

Key learning take-aways; what you need to know

The pandemic has resulted in a 'digital revolution' in Solent, with the rapid acceptance of remote consultations as an acceptable element of clinical care.

The delivery of care remotely isn't a 'lift and shift' exercise. Consideration needs to be given to both technical and emotional factors.

Training in IT skills is necessary and there are additional training needs in communication and other clinical conversations when working remotely.

Remote consultations are highly acceptable to patients, and should be considered by all clinicians. There is a significant opportunity to further personalise care by discussion remote options for patients rather than assuming 'clinician knows best'.

Spotlight on Frontline Teams

Changes in response to COVID-19

In response to COVID-19 frontline clinical teams went through a rapid transition. Clinical services were adapted to ensure that those people who needed face-to-face care continued to be seen.

Data sources:

1. Interviews with those working on the frontline.
2. Ethnographic notes from observations and meetings with people working on the frontline.

What we heard:

With the rapid onset of lockdown and a need for services across the healthcare system to adapt at speed, enabled much-needed change led by clinical teams. Frontline teams had increased autonomy in making decisions about care and services centred around one goal; the person in Solent's care.

For many, this shared goal unified teams with a sense of togetherness and a 'can do' spirit, enhancing collaboration within Solent services as well as the wider health and social care community.

Autonomy and enablement

Collaboration, integration and innovation

Leadership and peer support

Autonomy and enablement

- The initial few weeks of Solent's response were characterised by rapid and significant change.
- For frontline services this meant adapting processes to enable face-to-face care when needed, and remote or virtual care and support for others.
- As acute hospitals acted to free up more space, community teams were rapidly required to look after more complex and unwell patients.
- Decision-making was often led by the frontline clinical teams; making clinically-based decisions of how services could run to best look after those within our care.
- Many found they were enabled to make change and decisions swiftly, with enhanced support from corporate services such as IT and Estates teams.
- For most, the removal of previous barriers to change and autonomy was empowering.
- Some teams in the community such as those visiting people's homes, felt there was an imbalance in support between themselves and inpatient areas, for example: guidance around Personal Protective Equipment (PPE) and risk assessment.

> Positive - shows what you can do when you're given the freedom to do it. The trust put in you counts for a lot.

> Lots of challenges around PPE. The Royal College guidelines are different to the Trust guidelines. I didn't want to visit patients without correct PPE guidance.

> Normal barriers are removed – it's amazing what you can do.

Collaboration, integration and innovation

The removal of barriers and local decision making enhanced collaboration, integration and innovation. Many teams talked of working across organisational boundaries effectively, with joint approaches to problem solving.

Frontline clinical, social care and community organisation teams thought innovatively about how best to provide clinical services for those within our care trialling new ways of working. The unified goal of care centred around patients.

Many front line teams received the support of redeployed staff and had to ensure that they were trained and able to work safely, whilst continuing to adapt services rapidly.

By removing barriers people many spoke positively about collaborating with other services and professional groups within Solent as well as integrated ways of working across the wider health and social care communities.

> The empowerment and ability to just get on has been refreshing. Local solution-finding has led to so much more connectivity; understanding different professions, different stressors, different ways of working. Much closer relationships with teams.

> The changes have brought us closer together as a team and increased joint working. More awareness of what each other do.

> Looking at issues and patient need from a city wide perspective, rather than one locality, has been really positive.

> It has removed barriers between services.

> Networks and collaborations have worked well. There are better pathways and improved services.

Leadership and peer support: the importance of team

The pressure of this time was undoubtedly huge, people were responding to looking after people within their care as well as dealing with the pressure of blurred boundaries between home, work and family.

Those in leadership roles spoke of the feelings of absolute responsibility for the safety of their teams and their patients, and the additional stress that resulted. Many worked very long hours to support and protect their teams.

Initially, the rapidly changing guidance around PPE fuelled by media reports impacted some frontline workers' perceptions of safety. These were also fuelled by different approaches and equipment used by different organisations.

There was a very strong sense of a 'can do NHS Spirit' unified by a shared goal giving clarity and purpose.

For many the support from leadership and teams was essential in people feeling safe and for mediating levels of uncertainty.

The support from peers and the ability to pull together helped people feel safe in work, even in times of uncertainty.

Feeling informed and connected helped people to manage changes in working practices.

"I'm finding that holding a lot of people's emotions can be challenging. There are staff members who are very anxious and everyone is on edge because their whole life is in turmoil and life generally is upside down. Because I'm a people manager it can be exhausting containing and guiding them through it.

"I have always been proud to work for the NHS and more so now. The way we have all pulled together and everyone is a part of that.

"It's really brought us together as a team in terms of collaboration and problem solving and utilising individual's skills. It's been a real challenge for our service and I think we've really risen to it. The temptation early on was to just stop – some of us were asking how?! But we really did, it was transformative

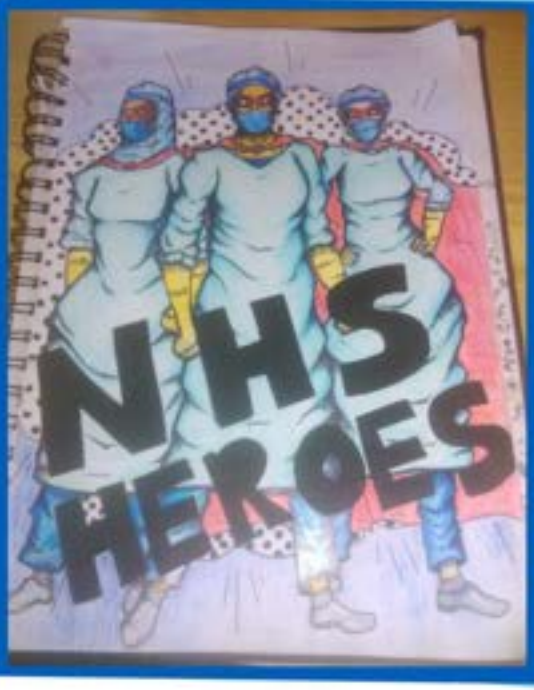
Short case studies

There are so many teams and services that demonstrate excellent practice, here are just a few examples:

Mental Health Community and Wellbeing Team:

This is the team that carry out physical healthcare checks on those with mental health illness, particularly those who are taking medication. They either administer the medication (when it is injected) or carry out physical health checks to assess for side effects etc. With lockdown, it wasn't possible to hold the clinics in person, and so the team had to reorganise themselves to be able to visit their 400 patients at home. It was a totally new way of working for the team; finding their way around the city, wearing PPE in the community, taking blood samples outside of the clinical environment.

The team developed a buddy system so that a clinician would visit the home, and one of their colleagues who was working from home would make the appointments and complete the clinical notes. This saved time, enabled home visits to take place, and ensured a system of peer support. The added benefits of home visits included being able to assess the broader aspects of wellbeing, and an informal food bank was set up by the team to enable the delivery of food packages.



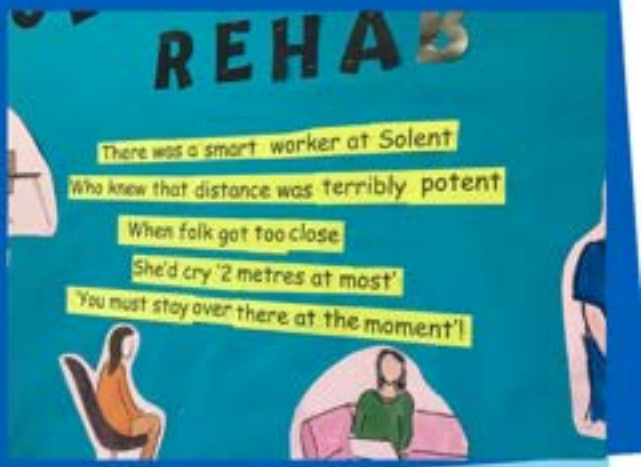
School Nursing - Portsmouth:

With schools closed during lockdown, it was difficult to continue to support and see families. The school nursing team worked with social workers to co-ordinate care across the city. Packs to create memory boxes, feelings boxes and other crafts were made for families and delivered; similar boxes to support healthy weight have also been provided, and supplemented with conversation being held by phone or WhatsApp. In one case, a single mum was living in a hotel room with three teenage girls and collaborative multi-agency effort enabled them to be rehoused, despite lockdown. The picture was drawn by a young girl from a family working with one of our school nurses.

Community Emergency Discharge Team (Southampton) and Community Nursing:

At the start of lockdown, hospitals were asked to discharge as many of their patients as they could back into the community; their homes or residential settings. A number of services joined forces to give a single point of access for the hospital teams. The Community Emergency Discharge Team and the Community Nursing (Twilight) and Palliative Care service joined with the Social Care Team (SCT), and located themselves together in Southampton. This included support from a number of redeployed staff who required a rapid programme of training (side skilling) and shadowing.

The teams worked together to keep as many people safely at home as they could (Home First) - the result, has been a much better understanding of roles and professions, not only within Solent but across different organisations.



Inpatient wards:

Solent has a number of inpatient facilities in both Portsmouth and Southampton. New inpatient facilities were also rapidly established in preparation for any need for bed capacity. Within the space of a month, teams built and equipped wards in both cities, additional staff were found through recruitment campaigns and a programme of redeployment.

Training and 'side skilling' sessions were held for staff to enable them to work in a ward environment; and infection prevention measures were checked, with addition PPE and

guidelines distributed across the county.

Learning for improvement

Many processes for approval of change can safely be streamlined and simplified.

Differing guidance and PPE equipment between organisations caused anxiety and confusion.

Many of the support mechanisms were easier to access for teams working at home, but it was difficult to attend Zoom or other sessions held through the day when working out in the community.

Learning from excellence

Empowering frontline teams to adapt and improve their services around patient needs led to rapid and successful mobilisation of services.

Clinical and corporate support services were able to work closely together to establish significant extra inpatient capacity.

Service adaptation was always driven by patient need – this enabled much stronger cross-sector and professional working.

Compassionate leadership across teams led to feelings of security and immense pride.

Key learning take-aways; what you need to know

Frontline teams who had increased autonomy in making decisions were empowered and enabled to create solutions that focussed on the needs of those people within Solent's care.

Communication, wellbeing and support strategies need to take into account the working environment and natural patterns of teams working in the community or on inpatient units (including housekeeping and catering teams).

Maybe those in leadership roles need equal access to on-going development and support to enable them to provide compassionate and personalised care to their teams.