NHS SCOTLAND

Re-mobilise, Recover, Re-design:
The Framework for NHS Scotland

COVID-19

Lessons Identified from the initial health and social care response to COVID-19 in Scotland

August 2021

Scottish Government
Riaghaltas na h-Alba
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Contents

1. Executive Summary

The purpose of this report is to provide insight from the Covid-19 response including lessons identified from Health and Social Care organisations within Scotland, supplemented by global case studies where appropriate. The timescale of this report has focussed on the first six months of the formal pandemic response, ranging from March 2020 to September 2020. In limiting the scope of work to this timeframe, this report is not intended as a comprehensive review of the full pandemic response, but rather considers what has worked well and conversely what improvements could be made so that Scottish organisations are better equipped going forward for any future waves of Covid-19 response, on-going recovery and remobilisation plans as well as future incident preparedness. It draws on a review of existing lessons identified documentation [1]shared from organisations across Scotland, insights from interviews with a limited number of stakeholders within Scottish Government and NHS Scotland, support by external research and engagement with organisations across the globe. The aim is that the insights from the first six months of the response could be used to inform the ongoing response to the Covid-19 pandemic and spread the actions that have worked successfully while flagging any pitfalls that should be avoided. This work also seeks to inform the future work of Scottish Government and health and care organisations, developing systems to retain aspects of new ways of working that should be continued during remobilisation and recovery phases of work.

Lessons identified have been synthesised from a dual perspective, both in terms of learnings gathered directly by Scottish health and care organisations, and supplemented through an additional global lens to lend wider insights into appropriate planning and response. Throughout this process we have refined the overall themes under which lessons have been categorised. Ultimately ten overarching themes have been identified based on this synthesis of international and Scottish findings, within which some further sub-themes have been added to result in sixteen individual categories. The graphic below summarises the ten key high level themes in this report, with the sixteen individual sub-categories shown on the next page.

Illustration 1: Ten Key Themes

01 Diagnosis and contact tracking

- Expanding access to testing and diagnostic services (e.g. remote chat bots, physical labs) and settling up the processes needed to trace contacts

02 Modelling of COVID-19 need, demand and consequences

- Tools to model scenarios if COVID-19 incidence, need and future demand for treatment, supply (beds, workforce, equipment) and the wider economic and social impacts including health inequalities

06 Programme and project management

- Need for more management and delivery capacity to help clients stand up their emergency COVID-19 control centres and implement essential initiatives rapidly at scale

07 Workforce augmentation

- Identifying and engaging emergency and volunteer resources, and mobilising those people to the treatment locations where they are needed
- Developing portals to support the fluid movement of staff between providers

[1] Existing documentation here defined as the documentation made available to the authors of this report until the 30th of October 2020 for the first phase of work. We recognise not all documentation will have been made available and there will have been subsequent documents not included within the scope of this report. Some additional documents were made available to the authors of the report for the second phase of work in April and May 2021 but again this is not intended to be comprehensive.

03 **Rapid establishment of extra physical capacity**

- Program/project management to stand up massive new care facilities
- Contracting between the public and private sector to provide capacity
- Scaling up social care during social isolation

04 **A supply chain that keeps moving**

- How to predict, then mitigate against, critical bottlenecks of equipment in the supply chain (ventilators, personal protection equipment etc.)

05 **Digital front door is becoming the normal front door**

- Call centres to connect patients with families
- Patient to provider communications that are secure
- Telecare/med channels that enable doctors to care for patients in their own homes etc.

08 **Governance, compliance and risk management**

- Procedures that ensure decisions are made by the right people and communications are clear and consistent
- Tracking compliance with requirements such as respiratory protection or cleanliness protocols

09 **Public Engagement and Education**

- Interacting with patients and service users to ensure services remain appropriate for their needs
- Ensuring the public engage with the health and social care system in the desired way during the pandemic response.

10 **New models of care**

- Restarting regular care within confinement restrictions
- Managing care backlogs and redesigning services to deliver
- Assessing plan preparedness and effectiveness for future waves

In producing the initial synthesis of documents included in this report, 161 lessons identified documents and outputs have been shared by 30 organisations across Scotland and reviewed. Through this process, a long list of findings and comments were made, which has been condensed down into a total of 97 lessons identified across the sixteen sub-categories below.

Following the production of these sixteen chapters, a targeted follow-up of three additional areas: the role of Public Health, Social Care, and the general Acute response was proposed. Direct engagement in these areas had been limited during the initial document review phase due to the on-going commitments during the pandemic response. This follow-up sought to gain further detail and insights into these three areas of the Scottish response through additional interviews and reviews of documentation. This follow-up continued to focus predominantly on the first six months of the pandemic response, and took place through April and May 2021. In completing this second phase of the work it is acknowledged that these consultations have benefitted from perspectives shaped and contextualised by hindsight and subsequent events. Some of this context is captured in the chapters in Section 5 of this report. Further detail on the scope and approach taken to these additional chapters is available in the main body of the report.

Findings:

From our review of lessons identified documentation available and conversations with identified stakeholders, there is clear evidence that a considerable amount of time and effort has been spent by organisations across Scotland to reflect on the first wave of the pandemic response, and to identify what worked well and what opportunities for further resilience are available as Covid-19 continues to present a challenge to the health and Social Care sectors. There are clear examples of good practice highlighted across individual NHS Boards and also as part of national programmes that should be reviewed and considered by those bodies reviewing this report. Some examples cited in the main body of this report include:

- The multi-disciplinary effort to stand up the **NHS Louisa Jordan** during the height of the initial response to the pandemic, drawing on support from across many organisations and teams. Teams highlighted the willingness of individuals at all levels within the health service and wider teams to move beyond existing roles and hierarchies and the attitude to make decisions at pace.
- The work of the **Health and Social Care Alliance (ALLIANCE)**, commissioned by the Scottish Government, assessing the impact of the first wave response on targeted patient groups to ensure inclusivity and maximum engagement. The pace of the initial response has limited the scope for significant public engagement as part of service changes and redesign, and this work will ensure person-centred care remains at the forefront of the on-going response plan.
- The work carried out through the **Scotland Connect programme** to pilot the distribution of both digital hardware and technical support for clinically vulnerable members of the public, to allow them to access digital healthcare during the height of the pandemic. This pilot provides a solid foundation for reducing access concerns with more rural and excluded populations across the country.
- The rapid **information governance approval** process put in place via Digital Health and Care to allow collaboration between different health organisations, including private hospitals.
- The **collective mobilisation of Public Health** teams at national and local levels as part of the pandemic response, providing sector-specific expertise alongside local insights. The key example of this highlighted in this report is the design and delivery of Test and Protect, which drew on cross-functional expertise to show the value of Public Health staff within NHS boards, and local outbreak control teams to manage the on-going pandemic response.
- The redesign of urgent care in response to the challenges faced by mobilisation. The **Redesign of Urgent Care (RUC)** project undertaken during the pandemic has been highlighted as an example of embedding new ways of working virtually, engaging with multiple teams in a collaborative way, and seeking to deliver the right level of treatment as close to home as possible. On-going evaluation of the programme will provide stronger quantitative evidence for its impact but qualitative feedback to date has been promising.
- The **collective mobilisation of local multidisciplinary teams from NHS health boards and local authorities** to provide enhanced oversight for local care homes and wider social care services was described by stakeholders as a key development during the pandemic. These arrangements, which build on foundations that were in place in many areas through health and social care integration, made a significant contribution to the development of protective arrangements for ensuring mutual aid and support for social care services who provide care to some the most vulnerable of citizens and the workforces supporting their care needs.
- The development and implementation of **safety huddle TURAS care management tool** within the care home sector. Stakeholders described the use of the tool as a valuable development during the pandemic for Social Care. The key elements of this were that it enabled a consistent approach to data collection, report staffing decisions and permitted early escalation and warning to allow for timely support and interventions for care homes.

We also found areas where stakeholders had reflected on the experiences from the initial response and identified opportunities for improvement as the pandemic continues. As above there are further examples and context cited in the full report, but the following cross-cutting themes were regularly raised by stakeholders:

- **The importance of collaborative working beyond existing organisational boundaries**. Stakeholders referenced the breakdown of perceived 'silos' as part of the initial response as a key enabler both within and across organisations, and it will be important to embed these ways of working going forward to maintain the reported benefits. Central to this collaborative working will be an on-going recognition that patient care extends beyond Acute provision in hospitals, and closer working with local authorities, primary and Social Care, as well as Public Health teams will remain crucial as the pandemic response evolves.
- **The increased role of digital tools in the provision of health and Social Care**. While organisations have been working towards digital care prior to the pandemic, this has seen a considerable acceleration. The strong foundations laid by digital teams have been a clear driver during the pandemic, but on-going support will be required. Organisations will have to ensure there is a sufficient level of workforce with the right skills to embed these changes, supported by infrastructure that facilitates increasing use of data across organisations.
- **The central role for use of data by health and Social Care teams**. From the start of the pandemic, the demand for significant quantities of real-time data from NHS Boards, Social Care organisations, the public, care homes and Scottish Government itself became clear. As with digital tools above, the considerable scale-up within organisations to manage this requirement now provides the opportunity for teams to use this data in a more meaningful way as part of a national data strategy that covers health and Social Care.
- **The agility and pace of decision making through governance due to changing roles and responsibilities**. Many staff referenced a feeling of autonomy or being empowered to act during the pandemic. While recognising that there is a middle ground between assurance and scrutiny and the pace of decision making, stakeholders regularly referenced a desire to capture what worked well and to not revert completely to previous ways of working. Two key drivers of this have been the experience of working towards one shared goal, meaning objectives were automatically aligned, and a breaking down of existing hierarchies towards a 'flatter' organisational structure where substantive roles became less important.

In completing the second phase of work to review three elements of the Scottish response in more detail, we found the above themes to remain consistent in our additional work. Additional messages that were identified that should also be considered by organisations as they look to recover, remobilise and plan for any future incidents include:

- **The importance of consistent and streamlined communications:** Across all three chapters, various stakeholders identified that there was much to be commended in the way in which Scottish Government and national organisations were able to manage and streamline communications. Interviewees also suggested that this could be an area for future review, reflecting on ensuring joint positions between organisations prior to issuing communications wherever possible, and providing sufficient time for organisations to be able to agree and act upon mandates. It should be noted that where timeframes for decision-making were constrained, it was not always appropriate or feasible for detailed consultations or joint consultations to take place.
- **The strategic use of national assets:** Particularly within the Acute response, interviewees referenced the crucial role played by national assets, including the NHS Louisa Jordan and NHS Golden Jubilee. Through the consultations held, we found evidence of how well these assets were used as part of response and early remobilisation. Some stakeholders also noted that there was a lack of initial clarity of the purpose and role of these assets, and that earlier commitments on the role and impact of these organisations would have allowed for a more efficient response. With the benefit of hindsight, clear strategic direction and mandates on how

and when such assets should be used therefore could offer opportunities for increased resilience.

- **Workforce retention and support:** Across all three chapters, we heard of the crucial role played by frontline team members in the pandemic response and recovery. All stakeholders recognised this and the ability of staff to work in a flexible way has been universally commended. As organisations now look towards remobilisation and recovery, the continued support and wellbeing offer for key groups within the workforce, particularly those highlighted through the early pandemic response in Public Health and care homes, will play a crucial role in ensuring the successful recovery of services after the pandemic.

Case studies provided within the main body of this report provide examples of what other countries have done differently both before and during their pandemic response. The case studies are **not** intended as examples of best practice, and have been chosen to show how other health and Social Care systems have managed different aspects of the pandemic response in the spirit of the 'lessons identified' purpose of this report. These are intended to provoke discussion and reflection on the Scottish response and not to highlight failings either within Scotland or internationally.

Conclusions and Next Steps:

We thank organisations for their involvement in this exercise, particularly where stakeholders have made themselves available for further consultations following the initial document review undertaken. Key findings have been identified above and those reviewing this report should consider how best to incorporate the relevant findings into existing response, recovery and remobilisation plans as well as future ways of working in general.

This piece of work has been intended as an illustrative, rather than comprehensive, examination of the first six months of pandemic response. It is intended to form the basis for longer term programmes of work considering the response to Covid-19, to draw on a wider range of perspectives and experience. The key to maximising the benefit of the lessons identified process carried out here will, therefore, be ensuring that this process continues to take place in some form when key individuals' capacity to engage is less restricted due to on-going management of the pandemic. It is therefore recommended that the ownership of lessons identified over the coming months is centralised within Scottish Government and that this process informs future work in this area. This will require clear definitions of roles and responsibilities between Scottish Government and wider health and care organisations to ensure there is no duplication of effort or overlap in how these exercises are carried out across organisations. Regular engagement with both staff and the public on their experiences as the pandemic response evolves will continue to highlight new learnings and reflections on what is working well and what could be improved. A central repository of these lessons that is easily accessible by any health and Social Care organisation, as well as a formal, on-going approach to lessons learned will ensure that pockets of good practice and suggestions for further resilience will continue to be identified and shared across the country.

We also note that within this report, there are findings and comments from organisations in the scope of this review that are not representative of all NHS Boards or Social Care organisations in Scotland. All efforts have been made to distinguish where comments have been made by only one organisation or by a wider group. While the findings are expected to be of interest to all those reading this report, it is recognised that some of the areas for improvement will not be relevant to all organisations if they have already been implemented or if local circumstances mean suggestions are not appropriate.

2. Background and Context

Covid-19 is the most significant global healthcare crisis in a century. While the speed and scale of the pandemic, and the response to it, has been remarkable, the impacts and changes caused will be profound and long-lasting.

Health and care systems around the world have borne the full brunt of Covid-19 and Scotland is no different. The pandemic has upended normal operations, backlogging an estimated 28 million procedures globally, exposed system and supply chain limitations, tested the physical and mental limits of health and Social Care workers and caused rapid adoption of digital solutions. Despite these extraordinary challenges, there are also opportunities to drive positive change through these difficult times.

Until a vaccine is effectively deployed across populations, health and care systems will need new ways of working to respond to these pressures as they move from crisis reaction through resilience, recovery and into the post-pandemic new reality. Covid-19 also has the potential to accelerate existing transformational changes that were already under way in more mature health and care organisations, and move us towards a new reality for health and care at a much faster pace than previously anticipated.

Covid-19 has had, and is still proving to have, a profound impact on Scottish society in 2020 and 2021, lending particular strain on health and Social Care services. By virtue of the ever-changing challenge posed by Covid-19, it remains crucial to take the opportunity to reflect on the lessons which can be learned from Covid-19 planning and response to date. Without suitable reflection and adaptation of approach, there is a risk whereby mistakes are repeated and/or successful lessons are not shared at scale to the benefit of the whole population.

3. Approach Taken

Insights produced in this report have been generated following four key areas of activity:

a. **A synthesis of lessons identified documentation** – a review and synthesis of the health, Social Care and central government lessons identified work undertaken during the first six months of the pandemic response in Scotland drawing out key themes.

b. **Options for further resilience not already documented in lessons identified** – where lessons identified have not been identified in the review of documentation provided, one-to-one interviews have been held with key senior leaders and individuals to seek their views on the most critical lessons identified – for example, within the Scottish Government Health and Social Care Directorate.

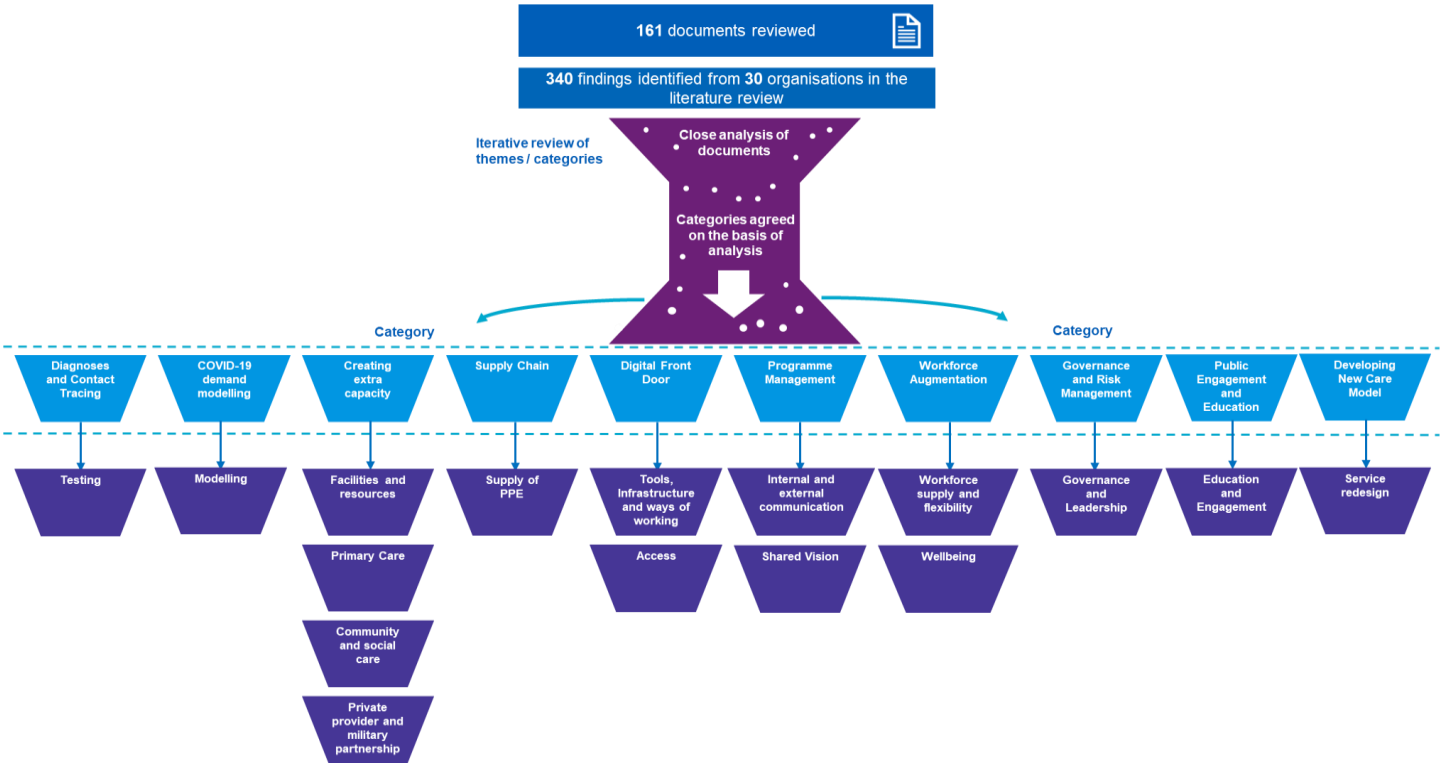
c. **Follow up review of key areas for additional focus** – alongside the two steps above, a targeted follow-up of three additional areas outlined in the executive summary (Acute response, Social Care and Public Health) to gain deeper insight through further stakeholder engagement and document review.

d. **International lessons identified** – we have drawn on international lessons identified through engagement with international teams facing similar problems across the globe to understand how they have approached the pandemic and where lessons could be identified to form part of the ongoing Scottish response.

The two graphics below summarise the process by which documents reviewed were developed into the ten key themes. The ten themes have then been defined more narrowly in the darker blue boxes below, which become the sixteen sub-categories into which this report is organised. These categories were presented in a number of meetings with SG colleagues and wider stakeholders for early testing and confirmation.

This report distinguishes between ‘areas of good practice’ and ‘opportunities for improved resilience’ considering both of these categories as lessons to be learned. The ‘areas of good practice’ are exclusively drawn from documents reviewed and stakeholder engagement within Scottish organisations. These are being showcased in this report to provide NHS Boards and other organisations within the scope of this work with suggestions for what is currently being done across other Scottish teams. The opportunities for improved resilience are drawn from suggestions from the outputs reviewed and interviews held, as well as independent research carried out using publicly available data and the interactions with international organisations. Due to the timeframe of this scope of work it is noted that there may be instances where these opportunities for improvement have been implemented and the learning from the first six months of the pandemic has already been acted upon.

Illustration 02: Process of Synthesising and Categorising Lessons identified



1. Source and review document		During the first eight weeks of this review (October and November 2020), 161 documents were reviewed from 30 organisations.
2. Identify lessons identified from literature		Following the review of documentation, findings and comments were collated. 340 such findings were noted, which were combined into 97 lessons across sixteen themes.
3. Group each lesson by theme		Themes were created based upon a combination of previous Scottish Government reporting and global research. Themes were changed iteratively based on the analysis of lessons identified.
4. Assess themes to similar global exercises		Themes were assessed in parallel to similar exercises, utilising global research and overlapping features/gaps of lessons identified were then identified.
5. Capture importance of lessons/ gaps		To provide stakeholders with guidance on areas for further focus, we have sought to prioritise the key takeaways and lessons from within the sixteen categories based on the frequency with which they were referenced in documents provided and comparisons with wider literature.
6. Identify case study for lessons/ gap		Where information provided permits, we have sought to provide a deeper insight into the Scottish response through case studies. International case studies highlight what has been put in place elsewhere. These are not cited as best practice; these are to provide insight into 'lessons learnt'.
7. Identify organisations for focus groups		Further gathering of lessons identified based on gaps identified has been undertaken in the form of focus groups and one-to-one interviews to provide further insight.
8. Guided follow up work through additional chapters		Additional targeted follow-up on three chapters (further detail on approach on the next page) across April and May 2021.

Follow Up Approach:

In the follow up phase of work, the Scottish Government's Health and Social Care Management Board requested a further follow-up into three additional areas given their prominence and contribution to the response in the first wave response to the pandemic:

1. The Public Health response
2. The Acute response
3. The Social Care response

This second phase of work was carried out over April and May 2021 but still focused only on the initial six months of the Covid-19 pandemic in Scotland. Scoping conversations were held with lead directors and identified stakeholders across each of the three areas as defined by the Health and Social Care Management Board to define the focus of each chapter. Due to the short timescales of this work coinciding with the pre-election period, there was a limit on the extent to which external stakeholders were able to be consulted.

The approach to each chapter was shaped in conjunction with lead directors for each of the areas. The Public Health response was devised through a series of workshops that built on shared reflections from Public Health Scotland, Scottish Directors of Public Health, and the Covid-19 Public Health team within Scottish Government. These workshops agreed key areas of focus, and follow-ups and further information were used to provide some of the detail that is shown in this chapter of the report.

The Acute response chapter was defined in response to three key questions set by the NHS Scotland Chief Operating Officer:

1. How well was the NHS set up to respond to the pandemic?;
2. How well were services stood back up after the first wave through the remobilisation of the NHS?; and
3. How well were services adapted or changed to respond to both the challenges and opportunites of Covid-19?

A series of individual and group interviews were held with identified members of NHS Scotland, Scottish Government, and territorial and special Boards to answer these questions and identify the key lessons from the first six months of the pandemic. The chapter sets out these lessons including examples where provided.

The Social Care chapter scope was defined as focussing in particular around care homes. This was agreed with the lead director during early mobilisation as it was felt that a major element of the Covid-19 response was the enhanced support provided to the sector through the enhanced professional oversight of care homes. Key themes were collated on the basis of targeted document review, and these were then tested in a series of sessions with Scottish Government leads who idnetified lessons from ongoing engagment with stakeholders through the pandemic groups established to support the pandemic response in care homes and social care, and examples provided to inform the drafting of this chapter. By focusing on care homes in particular, it is still expected that identified lessons will be applicable more widely to social care with care homes serving as a case study for the pandemic response.

Relationship between the sixteen overview chapters for lessons identified and follow-up chapters:

The follow up work in Section 5 provides an increased level of detail compared to the initial sixteen chapters in section 4 of this report.

Where relevant, information provided during the second phase of work draws on that provided in the first phase of work and brings this up to date. However, very limited changes have been made to the information included in the sixteen high-level summaries as this was not deemed to be in

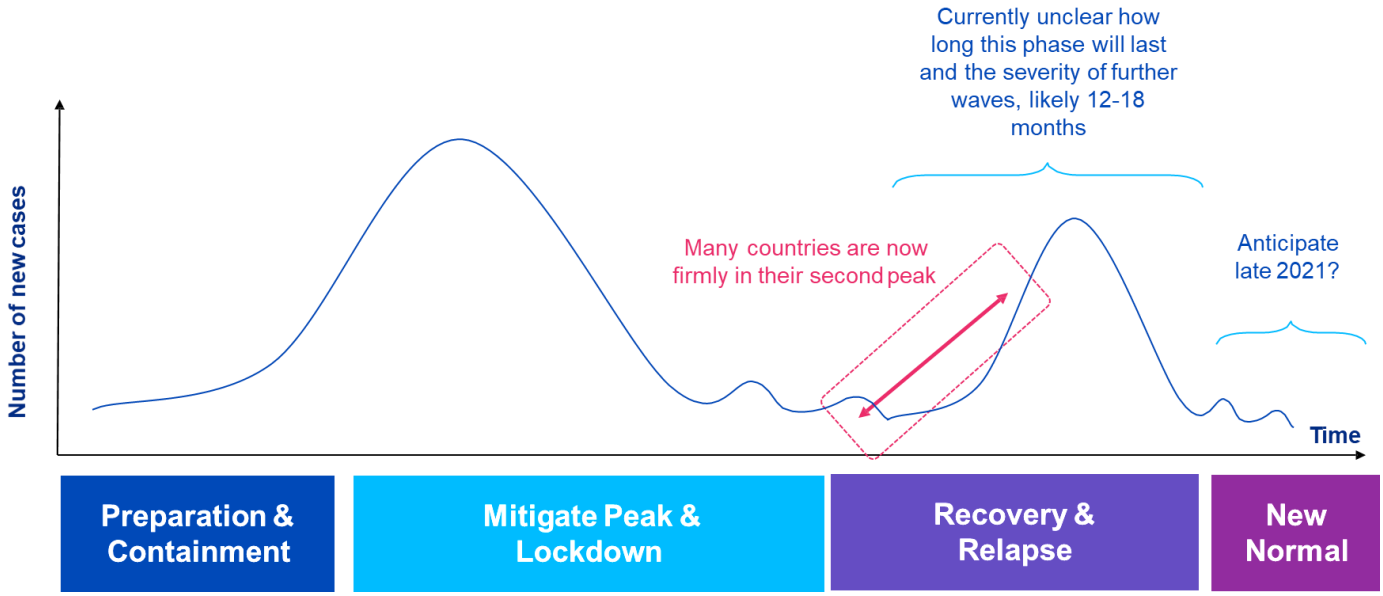
scope, and would have created inconsistencies between those areas followed-up and those that were not. Where there are overlaps between the three updated chapters, Section 5 of this report contains more updated information and should be used for reference.

We recommend that colleagues review the first sixteen chapters for a higher-level distillation of early lessons identified activity before reviewing the additional follow-up chapters for further detail if desired.

4. Lessons identified by Theme with Supporting Scottish and Global Case Studies

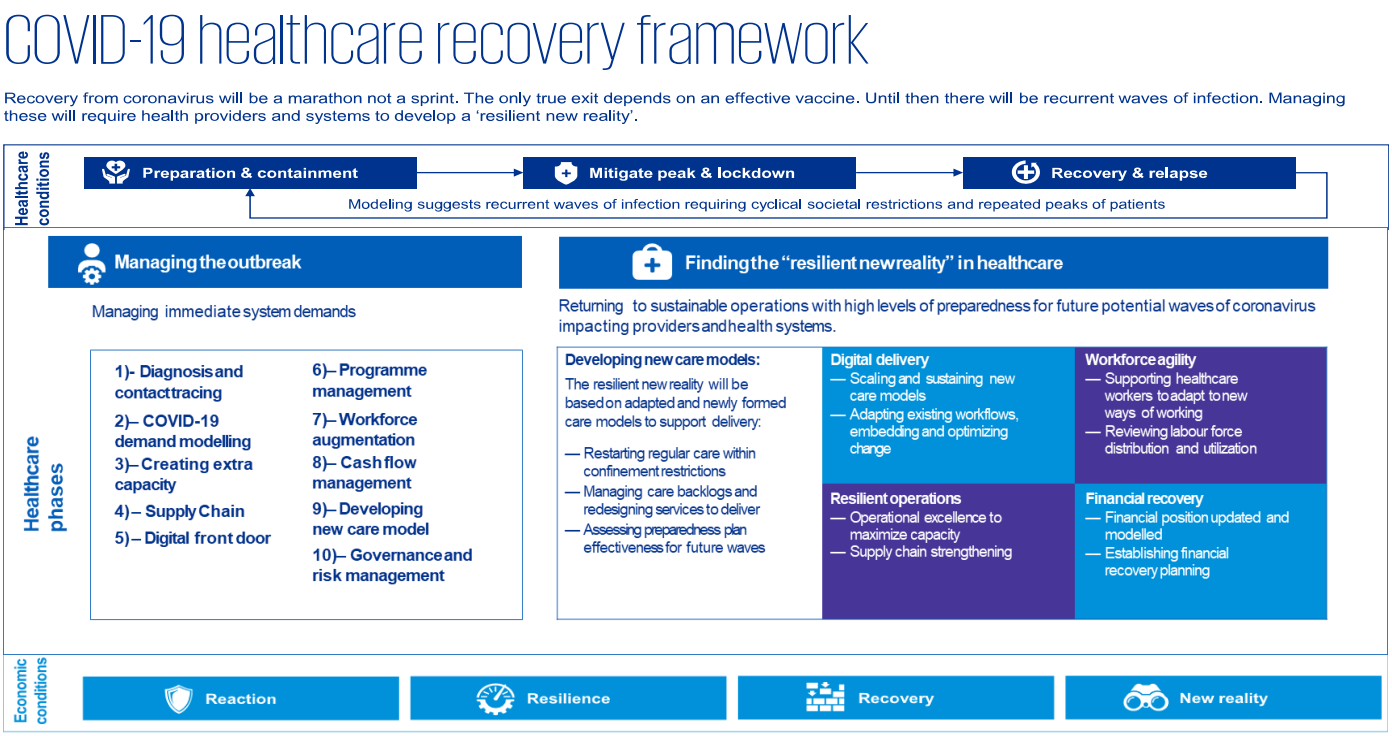
Governments around the world have followed similar paths as the pandemic evolves, seeing eight pandemic management phases – from international travel restrictions, through vast closures and to the gradual easing of restrictions. These phases correlate and influence the rate of rise and decline of the pandemic. Health systems around the globe have responded to the immediate challenges of Covid-19, began to recover services, but are now back into a period of disruption and uncertainty with the second wave and rising infection rates.

Illustration 03: How Systems Follow a Similar Path as the Pandemic Evolves (taken from KPMG International in November 2020)



Since the onset of Covid-19, a number of trends have been observed both within Scotland and internationally. Using the framework below, these trends have been mapped to the pandemic's health conditions, healthcare recovery phases and wider economic circumstances. This framework has been used to ensure those lessons identified within the documentation provided by Scottish organisations are appropriately grounded in similar lessons being identified worldwide. The ten key categories as referenced in Section 1 of this report are covered by the fifteen items below, and therefore are satisfied that the lessons identified are sufficiently comprehensive. The one category not covered within the scope of this report relates to cashflow management, and no lessons were identified by Scottish organisations given the nature of funding provided centrally for the pandemic response.

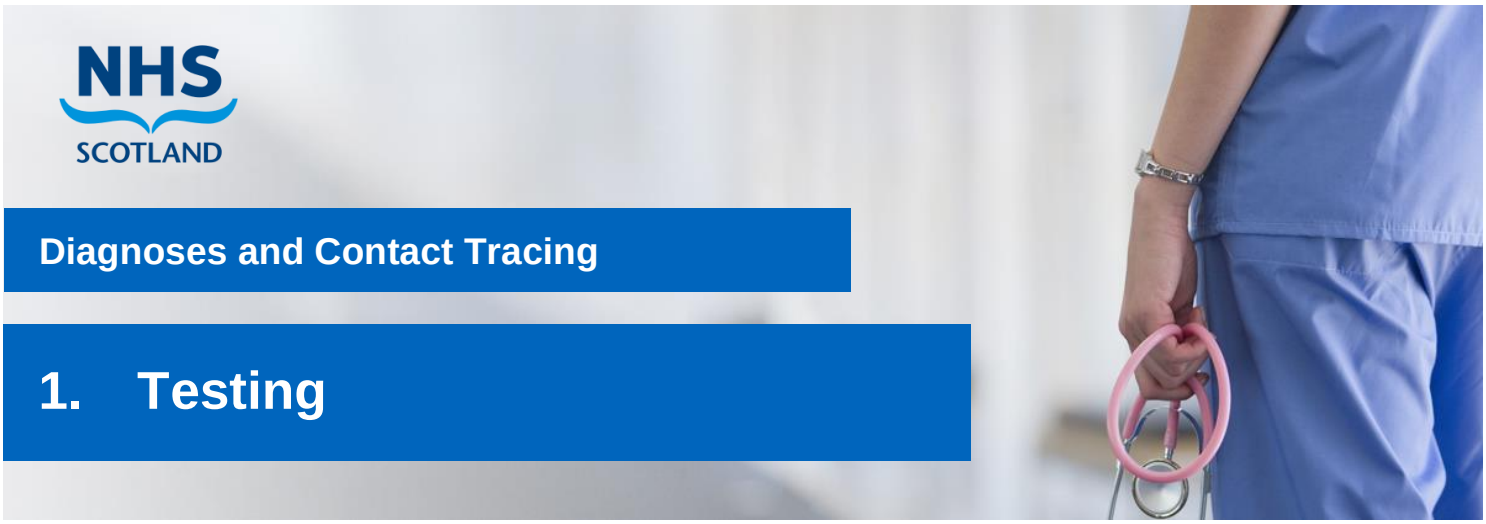
Illustration 04: Covid-19 Healthcare Recovery Framework (sourced from KPMG International)



COVID-19: Recovery and resilience in healthcare: Global insights, practical advice and tools to help healthcare leaders build and sustain a resilient new reality, KPMG International, 2020.

For each of the 10 themes we have in the following pages summarised:

- The challenge facing Scotland;
- **What has worked well** in Scottish organisations so far (based on outputs from this exercise);
- **Opportunities for further resilience** in Scotland where they have been found;
- **The key takeaways** for leaders; and
- Case studies across Scotland and international organisations that provide some additional insight into how organisations are dealing within specific problems as part of the Covid-19 response. Contact details are not publicly published here but are available for international case studies if desired.



Diagnoses and Contact Tracing

1. Testing

What is the challenge?

The implementation of an effective, nation-wide testing strategy involved a wide range of functions within Public Health. The purpose of testing itself has also evolved throughout the pandemic response, from supporting patient care through positive tests, testing key workers to prevent further transmission, and to wider population testing to understand transmission patterns.

Frequency and impact of lessons identified

Through the review of documentation provided from previous lessons identified sessions, very few organisations discussed the impact of Covid-19 testing either on their staff or their priorities. While testing remains a key issue in the Scottish Government's response to Covid-19, the lessons will not be relevant to all organisations in scope equally given the involvement of national bodies and Public Health teams.

What has worked well in Scotland?

- Public Health Scotland noted that links with colleagues across England, Wales and Northern Island were vital in terms of supporting learning, sharing best practices and receiving notifications on early warnings around issues.
- Stakeholders talked about clear public engagement when setting up testing sites to ensure optimum uptake within communities. This was felt to be particularly strong when engagement was led in conjunction with local Public Health teams: with examples cited including engaging early with international students and older people to determine where testing sites may cause concerns due to lack of public transport or proximity to other high risk areas.
- The role of digital in reporting test results has evolved throughout the pandemic, with a completely new system being implemented by the National Notification System to support this, working across Boards and with DHI. The Data Intelligence Network has also been cited as a lasting legacy for the Public Health response.

Opportunity for further resilience

- The impact of 'Test and Protect' will need to continue to be monitored as staff who have contributed to that work are brought back into their normal workplaces. UK testing centres have reported staff as a key 'bottleneck' as scientists return to academia for example. Organisations will have to ensure an appropriate balance between restarting existing laboratory work processes over the winter months, and increasing testing capacity through the regional testing hubs.
- Considering the attention drawn to contradictory guidance, one organisation highlighted the need for Scotland-specific solutions, including a clear strategic framework for Test and Protect that aligned with wider, UK government approaches. A specific example cited was weekly

Opportunity for further resilience

testing in care homes. More clarity on where the responsibility lies for testing both within Scottish Government teams and in the relationship between Scottish Government and the UK Government would allow for more tailored, local responses.

- A recent clinical review by Scottish Government has highlighted the importance of faster turnaround times for test results and increased capacity. A highlighted priority in this report is increasing routine testing to mitigate the risk of asymptomatic transmission (for example in care homes).

Key takeaways for leaders

- Resourcing remains a challenge. Despite the considerable work done to identify teams, increasing testing requirements will increase the need for specialist skills. Closer working with non-healthcare organisations could support this.
- Clarity of roles and responsibilities between Scottish Government and other UK bodies both in communications and decision-making will continue to support a more tailored, Scottish response for issue such as rurality and engagement with the islands to provide rapid testing and results.

2. Capacity and Demand Modelling

What is the challenge?

The Covid-19 pandemic has highlighted the importance of modelling capacity and demand, both with regards the transmission and extent of the virus, but also the impact on hospitals and Social Care for increasing demand for patients and service users, staff, and PPE among others. This will continue to play a key role as elective work is restored across the country.

Frequency and impact of lessons identified

Limited modelling information covering initial Covid-19 demand capacity assessment or for PPE supply chain analysis was found in the documentation. Through follow-up consultations, interviewees have referenced the significant work done on demand and capacity and PPE modelling through the early months of the pandemic, particularly from a virus transmission perspective.

What has worked well in Scotland?

- As noted above, few outputs from lessons identified exercises discussed the impact of modelling on the first wave response to the pandemic. Where multiple interviewees felt that the Scottish approach worked well however was a reflection on how quickly the infrastructure supporting modelling was stood up during the first few months of the pandemic. This significant investment in infrastructure provides decision makers with clear evidence for short-term decision making.
- One interviewee also referenced some initial work towards integrated modelling within NHS Boards. Ayrshire and Arran was cited as having made good progress to date by engaging with wider organisations within the region as part of their modelling.

Opportunity for further resilience

- A key area for improvement relates to the connections between demand and capacity modelling outputs at the national or board level, and its translations into 'on the ground' decisions across health and Social Care. A reported lack of integration between health and Social Care meant that the impacts of the modelling could not be easily cascaded through Boards into individual organisations. Further integration will continue to improve the efficiency of this process.
- A second area for further resilience identified was the involvement of team members on the modelling process. Few individuals within the Scottish Government have the required experience and expertise to be able to design, use and interpret the outputs from the models, meaning increasing demands on their time and bottlenecks around decision-making. Where further resource is deployed to support these individuals, there is not always the requisite experience to be able to support appropriately, and key individuals as a result continue to act across a number of roles. This presents a short-term risk to capacity and a longer-term risk to

Opportunity for further resilience

sustainability in post. To mitigate this, identification of individuals either with suitable existing skills, or a process by which these people can be upskilled, will support increased resilience.

- We also found evidence that while considerable work has been done on demand modelling scenarios, the unpredictability of the virus means wide ranges of potential outcomes are provided for any scenarios modelled, and no predictions can be made beyond six weeks with any great certainty. This can lead to reactive decision-making and inefficiencies. Organisations will either have to continue to work with available data and make decisions in the context of heightened uncertainty, or continue to focus resource on the modelling approach to provide longer-term data sets. We note here these comments do not reflect the considerable uncertainty inherent to the novel Covid-19 virus and therefore further certainty may not be possible.

Key takeaways for leaders

- Significant progress was made standing up the infrastructure and teams to model the impacts of Covid-19 on NHS Boards and the public, and this should be recognised and commended.
- Further operationalisation of modelling outputs remain challenging due to uncertainty inherent to the data and a lack of integration across organisations. Dealing with many individual bodies to translate modelling figures into decision-making presents a challenge.
- Skills and experience in modelling remain quite specialist, with limited support available to understand assumptions in the data. Leaders should ensure adequate support remains available to modelling teams to support wellbeing over the coming months and a pipeline of future resource is appropriately identified and monitored to cope with on-going demand.

What is the challenge?

Adapting existing physical facilities to enable the practice of social distancing and the functioning of green/blue (or hot and cold) sites, whilst maintaining non-Covid service provision, was challenging for organisations. There have also been reflections on the increased provision of critical care and how hospitals have adapted to this.

Frequency and impact of lessons identified

Through our review of documentation, few organisations talked about the physical adaptions made across and within sites to treat Covid-19 patients separately to non-Covid patients in detail. As organisations seek to restore elective work while ensuring staff and patient safety, this will continue to present an opportunity for further review based on the findings of this report.

What has worked well in Scotland?

- NHS Grampian noted that considerable time had been invested into safeguarding GP practice staff as layout changes were implemented to maintain social distancing. This was complemented by other safeguards including using alternative buildings and staggered hours to support effective distancing.
- The estates team of NHS Highland have been working closely with Acute and community clinical teams to physically return space to the 'new normal' working environment. In addition to this, buildings and departments have been reconfigured to more effective service delivery by taking into consideration lessons identified from wave one.

What has worked well in Scotland?

- NHS GGC has created a 'social distancing and workplace risk assessment' to be reviewed every 6 months that identifies key considerations for teams, and where estates may be able to support safe distancing within wards.

Opportunity for further resilience

- In outputs shared through this exercise, a small number of organisations have noted that through the work done by Boards in conjunction with Estates and Clinical teams, there is a sense that those working on non-Covid work were being deprioritised. With high priority non-Covid procedures only being performed during the height of the first wave, it will be important to provide sufficient operational and clinical focus on non-Covid work in subsequent waves. While no specific comments were made in the documentation provided, the case study below identified staff feedback around the process through which staff were selected to be part of hot or cold sites to ensure this is transparent and equitable.
- As outlined in further detail in the case study below, considerations around zoning of hospitals or sites must be assessed with both staff and patients. Regular feedback on the accessibility of sites, effectiveness of Infection Prevention Control (IPC) procedures and feelings of safety for staff and patients will be important aspects of maintaining elective care over the winter months. Increasing audit procedures around IPC may become more important to maintain the distinction between hot and cold sites.

Key takeaways for leaders

- Where physical adaptations are made to existing or new sites, consultation with patients, staff and trade unions remains crucial to ensure both buy-in and all feedback given can be considered to provide the best possible care.
- Communication with staff and patients about the process of zoning is important, particularly where redeployment is required across sites.
- On-going reviews of the 'new normal' will be needed to embed aspects of redesigned services that can be maintained and embedded going forward.

3. Primary Care

What is the challenge?

The response to Covid-19 has led to a rapid change in how general practice operates. A significant acceleration of the use of remote consultations has meant that while continuity of care was possible, the way in which the public interact with the service has fundamentally changed for most patients. Combined with the backlog of unmanaged conditions that has built up over the first response, primary care continues to face significant challenges.

Impact and Frequency of Lessons identified

Many references were made to the expanded role of primary care as part of the outputs provided to date. As with the findings for social and community care in the following section, these predominantly focused around the importance of a coordinated, wider response to the pandemic beyond hospital-based care.

What has worked well in Scotland?

- As outlined above, the key focus of what worked well for primary care in Scotland is the acceleration in the use of remote consultations. Many organisations reported significant uptake of digital tools, with the national Near Me TEC leading on work related to 'ihub' which was used to provide a standardised process for rolling out Near Me across 652 practices with 100% engagement. A series of 'Primary Care Resilience' Webex sessions have been recorded and remain available through 'ihub' for colleagues across health and Social Care as response continues over the winter months.
- A smaller number of organisations also referenced an increased offer of services to the public through primary care as part of the response to the pandemic. Examples provided during this exercise included the use of primary care teams to talk to patients about shielding or having Key Information Summaries (KIS) prepared proactively (increase of 4% to 17% of Scottish population with a KIS now prepared). Other Boards also noted an increased access by primary care teams to diagnostic services, which supported urgent cancer referral decisions into secondary care.

Opportunity for further resilience

- Research published towards the end of 2020 suggests that the pandemic response has exposed a significant gap between Public Health and primary care, and between local government and primary care teams. While we found evidence of some expanded services being provided above, other organisations noted that the strengthening of this relationship (and therefore the range of services that could be offered through primary care) would be important in the future.

Opportunity for further resilience

- Organisations also noted that while the uptake of remote consultations has been significant, one Board in particular noted that there was a preference for telephone consultations amongst GPs which lead to a lower than expected take-up of Near Me. Further follow-up on this would provide insights into potential barriers to the use of digital in primary care, but we suggest (in line with other findings in this report) that access to digital tools and limited infrastructure may continue to impact full digital roll-out across primary care.
- When reflecting on the lessons from the first wave of this response, a number of organisations noted that an increasing focus on scheduled care through general practice provides the opportunity to minimise existing pressures on secondary and tertiary care. A key area for focus was around how existing contractual and funding arrangements are no longer appropriate for this expanded role, and that new arrangements could improve resilience in the future.

Key takeaways for leaders

- Central source of guidance, tools and case studies available through Healthcare Improvement Scotland.
- A wider range of services can support more effective primary care but needs close alignment with local government and Public Health teams to ensure consistent provision of care.
- Continued uptake of digital consultations will be important but recognise there may be barriers around access and infrastructure in the community.

Creating Extra Capacity

4. Community and Social Care

What is the challenge?

The impact of the pandemic on people using Social Care services and staff has been significant. Both a Kings Fund report (focused on England) and the Independent review of social care in Scotland indicated that Covid-19 effectively highlighted and intensified existing challenges facing the sector including workforce issues, a lack of integration with other services pre-existing inequalities especially for older people.

Impact and Frequency

Many of the documents reviewed referenced the important role of non-hospital care in the response to the pandemic to date. We also found regular references in interviews on other topics (including digital and modelling discussions) of the role of community and Social Care as part of the wider response to the pandemic.

What has worked well in Scotland?

- A number of organisations have referenced the good work of the Health and Social Care Partnerships across Scotland, with a particular focus on the redeployment of staff to share lived experiences across organisations to identify lessons. More integrated leadership and decision-making has been referenced as being successful where it takes place. These developments have been mirrored in social care organisations who had to adapt quickly to new and difficult circumstances – the Independent Review of Social Care reported that some people who work in social care support felt they have been able to make decisions more quickly, to good effect.
- Building on the work of HSCPs, the collective mobilisation of local multidisciplinary teams from NHS health boards and local authorities to provide enhanced oversight for local care homes and wider social care services has been a key development during the pandemic. These arrangements have made a significant contribution to the development of protective arrangements for ensuring mutual aid and support for social care services who provide care to some the most vulnerable of citizens and the workforces supporting their care needs.
- The development and implementation of a safety huddle TURAS care management tool within the care home sector has been a valuable introduction. The key elements of this were that it enabled a consistent approach to data collection, report staffing decisions, and permitted early escalation and warning to allow for timely support and interventions for care homes.
- NHS GGC's six health and Social Care partnerships have been collaborating throughout the Covid-19 pandemic, which has been described as instrumental in delivering a GGC-wide response which involved a rapid and wholescale review of service provision; redesign of service delivery and access pathways; and significant changes to working practices.

Opportunity for further resilience

- A number of organisations within the scope of this work called for an increased focus on non-hospital care. These concerns firstly discussed funding and contractual arrangements, specifically requesting that social and community care colleagues are present when agreeing new funding arrangements to ensure there is sufficient focus on the full patient pathway. Clarity over funding for additional Social Care costs incurred, as echoed elsewhere in this report, has also been cited here.
- A second opportunity for further resilience raised by organisations was around a perceived disparity between social and healthcare staff. Examples cited here, which were confined to the early weeks in the pandemic, include the ability to access testing and PPE within Social Care settings. While these issues have been resolved, there were concerns raised at the time around whether social care was prioritised sufficiently in the early phase of the pandemic.
- In wider discussions around workforce planning and modelling, there was a sense that limited information was available from the perspective of non-healthcare organisations. Limited integration and information was felt to impact the effectiveness of planning.
- The range of organisations contributing to the community care response has also been highlighted as a potential opportunity for resilience. NHS Boards reported having to deal with hundreds of individual organisations separately, which impacts their ability to coordinate activities and make decisions at pace. An effective structure for coordination and governance could improve alignment across the health and Social Care sectors in the future.

Key takeaways for leaders

- Cross-organisation and specialty working to respond to the pandemic has highlighted the importance of whole system understanding to understand as many elements of the response as possible. Continued close working relationships and involvement in decision-making and in providing integrated flexible support and mutual aid to support social care organisations will be crucial during remobilisation and recovery.
- It will be important to continue to support equal access across health and social care services particularly with regards access to PPE, testing for staff members and access to wellbeing resources and support.

5. Private provider and military partnership

What is the challenge?

As part of the national response to the pandemic, the Scottish Government drew on the support of military partnerships to fill identified resource and/or skills gaps. While this worked to address the immediate challenge, it also raises the risk of a reliance on this into the longer term. Organisations should consider the extent to which this external relationship is appropriate as part of remobilisation and recovery, or whether internal solutions are to be sought to decrease on-going reliance on wider system partners over time.

Impact and Frequency

Few organisations referenced the role of military or other providers in their lessons identified outputs to date. We noted from follow-up consultations that colleagues referenced the important role the military in particular in response to the first wave, but that the availability of military input and private support was not uniform across Scotland.

What has worked well in Scotland?

- Where involved, organisations referenced the specialised input of military colleagues into disaster response plans as particularly valuable as it provided a skillset and mindset not always available within health and Social Care. Tabletop exercises, when conducted with military liaison officers, provided a greater understanding of how an organisation may have responded differently to the first wave.
- One organisation also recognised in their lessons identified that they do not have the capacity or the capability to deliver Covid-19 programmes alone. They reflected on the close relationships with partners to bring in external project and programme management as something that worked well, particularly highlighting that military colleagues brought a focus on quick decision making and pace throughout the initial stages of the crisis.
- Partnerships have also been strengthened through in-housing new resource using secondments and partnering arrangements with Higher Education. These temporary solutions could provide lasting benefits in terms of building working relationships and providing exposure to new skills.

Opportunity for further resilience

- Organisations recognised that the response to the pandemic evidenced a level of reliance on a range of private and independent sector providers across care homes, care package providers, supply chain resilience and testing. These organisations will need to consider whether or not this is desired over future waves and into the 'new normal'. If so, then private and independent providers should be involved more closely in future decision-making and governance. If not, arrangements must be made to reduce this reliance through increased in-sourcing and capacity.

Opportunity for further resilience

- Health Education England have also agreed to register private providers as recognised training sites during the response to the pandemic. This means that on-going training can be provided for NHS workers to develop appropriate skills for the future as backlogs are addressed through private providers. We have not been made aware of similar arrangements in Scotland through this work.
- Discussions with Boards revealed that not all regions have similar access to private or independent provision. If central decisions are made around how best to increase capacity using other organisations, regional availability and differences must be considered.

Key takeaways for leaders

- Assess the strength of existing networks to private/military partners to identify gaps over the coming months, particularly where Boards have less access to private providers if this will be considered across the Central Belt.
- Recognise capability gaps within Boards and develop plans to address where appropriate through joint arrangements or recruitment.
- Consider the impact of non-NHS involvement on addressing backlogs of care and how this impacts training provision where staff may not be registered with independent providers.

Public Engagement and Education

6. Public engagement and education

What is the challenge?

A key element of the health and social care response was managing public awareness through engagement and education. Through this exercise, we have found evidence that organisations feel lessons identified from the engagement approach to date could be used to support provision in the future. Increasing demand for services will continue to impact organisations, particularly as underlying issues resurface in the coming months, and engaging with the public to manage expectations and increase awareness of how best to engage with services will remain crucial during recovery and remobilisation.

Impact and Frequency

Where documentation referenced public engagement, these referred to concerns about the limited timescales available to hold meaningful engagement with patients and service users prior to changes being made that impacted them. There were otherwise limited references to how the public could be engaged.

What has worked well in Scotland?

- Many organisations recognised the importance of engagement with public and patients across a number of mediums, including coordinated social media and television campaigns, to deliver key messages consistently to all relevant groups. According to respondents from Health and Social Care Scotland, there was a feeling that communications being shared from those in senior leadership positions have been more impactful with the public, particularly where more emphasis and impact is needed.
- Most of these organisations also recognised that specific work had been done to better reflect diversity across population groups, recognising challenges around specific conditions and digital inclusion. A number of interviewees referenced the on-going work of the Health and Social Care Alliance (ALLIANCE) in this space, and the outputs of this work should continue to be reviewed as more insights become available.
- Two interviewees noted that updated guidance on patient inclusion was issued for NHS Boards during the pandemic to reflect the challenges around engagement during the pandemic. This updated guidance should allow Boards to make best use of heightened interest of the public in their engagement with the health and care service.

Opportunity for further resilience

- Many outputs reviewed drew attention to a premise that a culture change would be required to shift attention from 'on-demand' health and Social Care to a service provided based on need. In light of this, suggestions have been made to better educate patients on how they can take greater responsibility of their health and well-being (e.g. improved signposting to sources of

Opportunity for further resilience

self-help). Likewise, bodies highlighted that messaging must be consistent. Opportunities arise when the messaging of promoting self-care, community self-support and of using the NHS and Social Care appropriately is aligned. The prioritisation of 'need' and support for the health system to deprioritise 'wants' will be critical.

- Some organisations suggested that education and communication should be co-designed with the public if not already done so. Fully inclusive co-design will ensure sufficient focus on the patient and include patient-centred care at the heart of remobilisation plans.
- The necessity of command and control-type governance during the pandemic has limited opportunities for public engagement. A key example cited has been the limits imposed on visiting practices without involving the public, and meaningful inclusion of the public in the shape of new services and approaches to responding to the pandemic is strongly recommended. Working with Healthcare Improvement Scotland to access citizen panels for example may support this.

Key takeaways for leaders

- Leaders should consider how communication and engagement can drive more of a preventative, self-care and community health emphasis. This would look to reduce strain on NHS services and adopting more of an educational approach.
- Organisations are reminded of their statutory responsibilities for public consultation on service changes, even during the pandemic. If lasting changes are made to services, prompt consultations will be required.

Supply Chain

7. Supply of PPE

What is the challenge?

The effective management of supply chain, particularly for PPE, was a crucial determinant of the early effectiveness of the pandemic response. Considerable work has been done by NHS NSS to model demand and provide PPE supplies to individual boards, primary and social care organisations. Reliance on global supply chains and challenges around the rurality of Scottish regions will have brought the provision of PPE into sharp focus for organisations and now informs future PPE planning for Scotland.

Impact and Frequency of Lessons Identified

While PPE remained at the forefront of many discussions during the first wave of the pandemic, our review of documentation provided did not find many references to how this has been managed within individual organisations. Where referenced, organisation reflected on the importance of appropriate PPE to continue to safely treat Covid-19 positive patients.

What has worked well in Scotland?

- Participants highlighted the effective supply management of PPE to be a key contributor to a successful response to date. NHS Western Isles said that even with increasing outpatient activity, they had managed the supply chain and application of PPE well during the first wave. Specifically, to allow for any Covid-19 surges, a buffer stock of two weeks' supply has been set aside by working closely with the local authority providing supplies of some PPE when critical supplies not delivered.
- Similarly, NHS Orkney set up a virtual hub arrangement to show the services that each partner would be responsible for in terms of the supply of PPE. This reduces the risk of inefficient stockpiling and aligns priorities across organisations to ensure available equipment can be identified and shared where required.
- NSS drew on its existing National Procurement team to work with Scottish Government, health and Social Care providers and local authorities to extend supply and sourcing efforts to centralise provision where possible. This has been facilitated through an online portal which provides real-time data, deliveries to Social Care hubs across the country and the creation of the NSS Warehouse Management System to provide extra capacity.

Opportunity for further resilience

- Despite some local initiatives being reported as successful, many Boards expressed "anxiety" around the availability of PPE, ventilators and national stockpiles. They have also expressed the fact that there should be clear and consistent messaging regarding the availability and management of PPE, and specialist equipment shortages.

Opportunity for further resilience

- As outlined in the sections of this report on primary and Social Care, organisations regularly drew attention to the availability of PPE in non-hospital settings. Involvement of wider groups in decision making will continue to raise awareness of any discrepancies between health, social and independent sector colleagues. This aligns with wider comments around the perception of equality between health and Social Care staff.
- Availability of real-time, accurate data is crucial for effective supply chain management. Closer working with digital and BI teams, as well as organisations within each region to capture accurate data, will improve the ability to manage PPE effectively.

Key takeaways for leaders

- The ability to rely on stockpiles of PPE has been critical to the success of some organisations but can also negatively impact on the wider response if stockpiles are used inefficiently. Collaborative working across sectors and organisations should mitigate this risk.
- Consideration into clear messaging so that less anxiety is felt by organisations in the delivery of services.
- Access to accurate, real-time data across organisations will provide a basis for more effective decision-making.

Digital Front Door

8. Tools, Infrastructure and ways of working

What is the challenge?

Organisations all recognised the significant challenge of integrating digital tools and infrastructure into existing pathways and ways of working. With a requirement to move towards more remote working, newly adapted tools were made available to facilitate services, with the majority of organisations highlighting Microsoft Teams and Near Me as key examples.

Impact and Frequency

Many organisations referenced the significant impact of digital tools on how they have responded to the pandemic to date. As part of the findings from our review of documentation, organisations regularly referenced digital as a key enabler for the response and an area for lasting change within organisations.

What has worked well in Scotland?

- Many organisations noted that Microsoft Teams has been the key digital tool to enable staff and services to work remotely during the pandemic. NHS Dumfries and Galloway drew particular attention to the benefits for staff living in rural areas, who have been able to participate in work activities they previously had difficulty attending, providing more opportunities for inclusion.
- Near Me was found to be a key tool to mitigate the loss of face-to-face provision. NHS GGC, among others, recognised that the rapid and widespread implementation of Near Me enabled the effective prioritisation of patients remotely and management of patients presenting at hospitals for unscheduled care.
- In terms of digital ways of working, NHS Orkney mentioned clinical services had fully embraced digital and aligned the rapid rollout of digital with the planning of future service delivery. Orkney also reflected in terms of digital being available to deliver a wider range of services, such as "digital training packages" that can be given to carers to help them understand and support a patient's clinical care.
- A rapid information governance process was put into place to ensure private hospitals (among others) were able to share data for using new digital tools through Digital Health and Care Scotland.

Opportunity for further resilience

- With an increase in demand for digital services, organisations have identified the need to consider assessing their existing IT infrastructure and additional capacity to ensure that clinical services and other enabling services can continue to function effectively.

Opportunity for further resilience

- National organisations regularly recognised increasing expectations and demand for data as a potential barrier moving forwards. From the start of the pandemic, there was a significant ask for real-time data which continues into the vaccination programme. As organisations scale up to provide this data, there is an opportunity for a new data strategy across health and Social Care to make best use of this infrastructure as part of remobilisation plans. The role of NHS Inform will be important here as a potential 'front door' for health and Social Care data in Scotland.
- A final area of focus on building the capacity for health and Social Care staff to use these tools. It was felt that there is an expectation staff will already have these skills, but new tools will require additional training and support.

Key takeaways for leaders

- Recognise that the rollout of digital tools will strain services if supporting infrastructure is not appropriately scaled up, particularly around integration of systems. In addition, service redesign, culture, leadership and skills are all important areas to evaluate alongside the integration of digital tools.
- Data has become central to the pandemic response. Leveraging this as part of the 'new normal' will provide opportunities to work more effectively and more closely with non-healthcare organisations.

Digital Front Door

9. Access

What is the challenge?

It is important to understand that as digital tools become more integrated into patient pathways and ways of working, stakeholders will be impacted differently. From a staff perspective, the ability to make best use of digital tools may be hindered if the required resources and infrastructure are missing. From a patient perspective, an inclusive approach needs to be adopted so that all stakeholders are considered.

Impact and Frequency

In the same way that digital tools were regularly referenced through outputs provided, organisations also recognised the impact of these tools on their stakeholders. There has been significant work done around increasing access as discussed below and organisations regularly referenced the importance of maintaing this throughout the response and recovery phases.

What has worked well in Scotland?

- The 'Connecting Scotland' programme (delivered in partnership with the Scottish Council of Voluntary Organisations) invested £5 million in providing 9,000 technology packages (hardware and support) to those at risk of digital exclusion. This programme has been extended as the response continues with the training of 'Digital Champions' to support users.
- SMS messaging services were developed alongside UK Government to support those shielding with food packages.
- Digital was highlighted as a key enabler for maintaining training and CPD during the first wave of the pandemic; NHS Borders specifically referenced the use of the LearnPro Competency Assessment tool here. Wider advantages cited using digital tools included: supporting cross sector learning with wider groups; improving attendance rates by enabling remote access; and the ability to record sessions. As a result (particularly of the ability to record), a repository of learning material has now been created, further improving access to training on-demand for the future.
- Participants have drawn attention to innovation in teaching being a steep but valuable learning curve, and the fact that this has paved the way to a new channel of learning, informing how teaching is carried out across the board.

Opportunity for further resilience

- To support the continued and increasing use of digital, organisations have noted that more consideration needs to be made in terms of access where stakeholder groups may be located rurally. Areas with less connectivity may not be able to access all services remotely, with organisations emphasising the need to review bandwidth and public Wi-Fi.

Opportunity for further resilience

- We also note specific work is being done through the third sector to consult on the impact of digital adoption on patients with different conditions; this should be reviewed and shared across the country as digital adoption continues. The ALLIANCE continue to work with identified groups of service users to understand how they have been impacted by Covid-19 and organisations should ensure the outputs of this work are considered during remobilisation and recovery.
- Equality impact assessments have been suggested to ensure that digital works for all stakeholders going forward. Recognising the extent to which digital exclusion exists will primarily inform the exercises that need to follow to address challenges in providing everyone access. We note through conversations with other stakeholders that these are being rolled out already, so ensuring all services and organisations are covered in a timely manner will be important here.

Key takeaways for leaders

- Recognise that digital will not come naturally to all and leaders must consider access issues, whether it be educationally or having the appropriate infrastructure, for certain stakeholder groups.
- Digital is a key enabler for access in many respects and leaders must consider how to roll this out more widely beyond Covid-19 response.

Programme Management

10. Internal and external communication

What is the challenge?

A number of organisations recognised the importance of clear communications as another “key enabler” for the response to Covid-19, with particular attention made to internal communications to stakeholders within health and social care. Barriers were identified around ensuring any guidance being received/shared within organisations was coordinated appropriately, whereas external communication was felt to have worked well by building public resilience through a planned and proactive approach.

Impact and Frequency

Regular feedback was provided by organisations on the lessons identified from internal and external communications during the first wave of the pandemic. Feedback was generally positive however, with limited areas for improvement based on the documents provided for this phase of work.

What has worked well in Scotland?

- Due to the volume of necessary communications from leaders, many organisations felt those that worked best were those focussed on actions and decisions, providing regular updates and clarity within organisations. Short, regular communications were felt to be the most effective way of keeping staff updated despite a rapidly changing landscape. Lessons from NHS Chief Executives in particular have suggested the need to build on this for the future under a dynamic blended model of remote and office working, for example where electronic communications cannot be supplemented by visual reminders within hospitals or practices.
- NHS Inform have produced a regularly updated Communications Toolkit which specifically provides guidance on engaging with those with communication differences (such as British Sign Language). This will remain important as guidance changes.
- Some organisations talked about the importance of tailored messages for staff and their families. NHS Fife talked about animations being made available for the young families of staff to deliver specific messages for them where uncertainty may have caused distress at home.

Opportunity for further resilience

- Possible improvements around the clarity of communications from Scottish Government into various organisations have been reflected upon by several organisations. "Constant changing guidance" was described as problematic with partnerships having to "continually flex" to short timescales, leaving little planning time going with a depleted workforce. We note from follow-up conversations that this has been recognised as inevitable, but a focus on regular engagement with Boards is planned as a mitigation for rapidly changing guidance.

Opportunity for further resilience

- Suggestions have been made by bodies to implement a coordinated approach to communication, making messaging clearer for whole organisations. Coordination and timing of communications will need to allow adequate time to develop high quality information and drive decision-making. As part of this, organisations referenced that specific guidance was targeted at different executives (i.e. clinical workforce guidance to medical directors rather than HR teams). This creates a risk of silos being created within teams with delays in guidance being shared. Joined-up, coordinated guidance would mitigate this.
- External communications to the public and other stakeholders remain crucial over the coming months, but feelings of uncertainty also impact staff within organisations. Interviewees referenced teams working to different versions of guidance within one organisation, and organisations should continue to ensure guidance and FAQs are regularly updated for staff as well as patients and service users.

Key takeaways for leaders

- Guidance to organisations needs to be coordinated and consistent. Constant changing guidance has been problematic to some organisations with particular concerns around version control.
- Consideration into keeping staff updated regularly throughout a changing landscape where staff are working flexibly across different organisations and at home. Consistency of message across digital and physical communications (i.e. in wards) will continue to be crucial.

Programme Management

11. Shared Vision

What is the challenge?

Alignment both within and across health and Social Care organisations provides the opportunity to work collaboratively and efficiently, but competing organisational priorities or a lack of clarity about aims and objectives can impact this. As found through this exercise, a number of organisations across the system noted that clarity of purpose in the short term provided a focus for decision-making, and the challenge facing organisations now is to ensure that shared aims and objectives continue to provide a targeted focus for staff and other stakeholders.

Impact and Frequency of Lessons Identified

While few organisations referenced how effectively responding to ‘one objective’ facilitated quick decision-making and breakdowns of silo working, those that did suggested this was a crucial learning from the first wave and may have a significant impact on future ways of working.

What has worked well in Scotland?

- Across a number of organisations, the importance of a clear mandate was noted as being important in the response to the pandemic. Participants regularly made references to clear mandates, well-defined purposes, and therefore the authority to act based on this common vision as allowing progress at pace and limiting conversations about competing priorities and focus for individual teams or organisations. This led to new innovations including NHS GGC's 'Give and Go' service for the public to share supplies with patients and staff on wards by engaging with voluntary organisations and staff networks.
- Many organisations also emphasised that the high levels of trust and support between colleagues as the common purpose or vision encouraged teams to move away from traditional, 'bureaucratic' environments. The rapid response to the pandemic was therefore facilitated by teams working towards an agreed, stated aim in a less hierarchical manner.
- We also found a clear recognition of this at a wider level by the Scottish Government itself, where document outputs directly referenced the fact that a clear and common purpose 'underpinned' the achievements made across health and Social Care during the first wave of the pandemic. Examples cited through interviews included the rollout of Near Me, where interviewees praised the ability to divert significant resources to one, prioritised and agreed challenge to deliver at pace.

Opportunity for further resilience

- Challenges highlighted in lessons identified exercises held to date talked about how existing priorities were not well aligned with the newly agreed 'common purpose'. Organisations felt that additional targets being set in addition to responding to the pandemic felt 'unnecessary' and 'added additional pressure' at a time of already heightened pressure. A specific example

Opportunity for further resilience

cited here was given around managing discharge times from hospitals. Staff felt the reason for targets at a time of pandemic were not well understood and they then could feel demoralised by criticism of performance.

- To mitigate this, opportunities for further resilience are available by ensuring that common purposes or visions are designed to encompass existing requirements where possible. Organisations could also engage with stakeholders about existing priorities while responding to significant events such as pandemics to determine whether or not priorities remain relevant or appropriate.

Key takeaways for leaders

- Ensure that there is an alignment between the new purpose and continuing with the core requirements/provision.
- A clear mandate and well-defined vision can work effectively, especially in rapid-response environments.

Workforce

12. Workforce Supply and Flexibility

What is the challenge?

Even before the pandemic, Health and Social Care organisations have been facing significant challenges around workforce supply, with an excess of demand over supply of staff. With increasing new demand presenting during the pandemic, as well as a growing backlog of work postponed in the immediate response, the supply and flexibility of the workforce presents a key challenge to Scotland over the coming months.

Impact and Frequency

Workforce was highlighted as an area for reflection across a large number of the documents reviewed as well as in the follow-up consultations held. Identifying a sufficient supply of appropriately skilled staff remains a key focus for Health and Social Care organisations, and this will have a significant impact on the on-going response to the pandemic as well as recovery.

What has worked well in Scotland?

- Few organisations have referenced additional supply of temporary/voluntary workforce during the response to the pandemic in the documents reviewed. Where this has been referenced, organisations noted that these staff will have clear insights and lessons from their experiences. We note none of these insights were referenced at this stage but will be an available area for feedback.
- A small number of organisations noted that rapid recruitment processes have provided an alternative way to manage the recruitment of large numbers of applicants over a short period of time. A key example of this at a national level is the work with NHS Education for Scotland to identify c. 20,000 additional staff within a month.
- With a need to flex resources in many places during the pandemic, many organisations praised the ability of staff to adapt and take on new roles where there was requirement to do so. Considerations were made in terms of skill/capability and whether staff where comfortable when taking up a new role when required.
- Efforts were made at national level to anticipate demand for staffing and clinical skills (at whole service level), with emergency guidance in place for staffing ratios in critical care and ICU which assisted in the deployment of student nurses during the first peak. Learnings from this allowed for more accurate predictions and enhanced decision making for future deployment in subsequent waves.
- Whole new workforces were created as part of the pandemic response with the speed and design, assessment and delivery highlighted as areas that have worked well, alongside the recognised value of mutual aid. One key example that was highlighted as working well was within Contact Tracing, regarding having a hybrid model of service delivery in place, with local capacity supplemented at national level with both directly employed and commercial resource.

What has worked well in Scotland?

This has proven to be very flexible but offers lessons to be learned about the need to take an 'insurance-based' approach to building capacity in the pandemic and emergency services.

Opportunity for further resilience

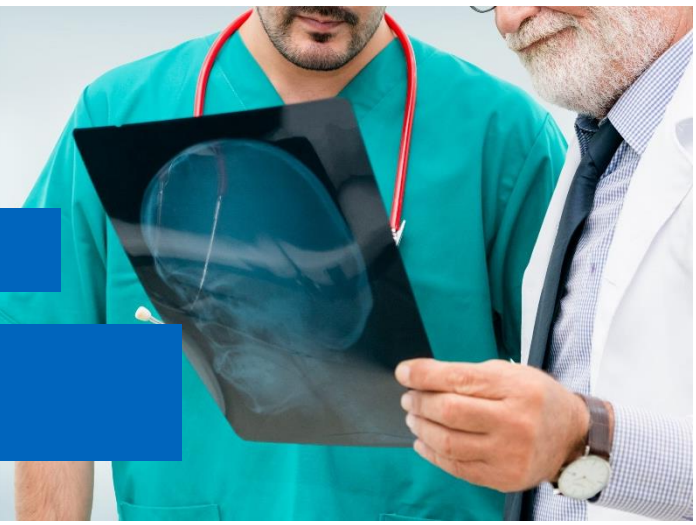
- Whilst bodies reflected on the need to meet initial demand with deployment of staff and/or recruitment of additional staff, the transition back to the 'new normal' presents a risk to the capacity of staff with specific skillsets. A key example cited within the documents provided is clinical skills, where clinical supervisors for non-clinical staff remain in short supply. Organisations also suggested that future planning could consider developing a matrix or system where skills and capability are considered and mapped across potential redeployments in advance, to facilitate the pace at which organisations can respond to changing requirements. Closer work with Higher Education Institutions or education practices might support this.
- Having the time to upskill staff during the onset of the Covid-19 pandemic was clearly a limiting factor. Documents provided noted the fact that certain staff groups were especially impacted in terms of learning and development, for example, with the pausing of clinical placements for AHPs in the first wave. This was exacerbated by the practical challenges of reintroducing placements whilst maintaining social distancing, as well as a lack of patient numbers to support a quality learning experience for students.
- Respondents suggested that the workforce planning exercise was heavily supply-led. The NES and SSSC Recruitment Portals were developed and implemented rapidly through partnerships working across the health and social care sector, which on reflection worked well. Boards, however, did not feel that there was enough focus on aligning efforts to seek temporary or emergency staffing to service needs. At the start of the pandemic, NHS Boards, Health and Social Care Partnerships and Social Care organisations did not know which parts of the workforce would experience the most demand and pressure and consequently, the Portals issued a general invitation to workers across the health and social care sector. This has led to an excess of available staff in the NES and SSSC Portals, for a number of reasons (for example, some of the vacancies were not in required geographical areas or services that Portal registrants wanted to work in and some registrants did not have the required skills that Boards or Social Care organisations needed). Another factor was that as a number of services had temporarily stopped, Health and Social Care Partnerships effectively redeployed staff locally, providing mutual aide to respond to workforce pressures. Going forward, more focus on integrated, flexible, demand modelling will improve efficiency of supply sourcing.

Key takeaways for leaders

- Recognise the value of volunteer staff in freeing up clinical staff to focus on my value-added activities.
- Consider the governance around rapid recruitment when trying to meet peaks in demand.
- Increasing digital provision of care impacts of role automation in workforce plans. Scottish organisations should review workforce requirements over the next 5-10 years considering how the pandemic response may have accelerated this process.
- We can take learnings from the initial waves of Covid-19 around how we can rapidly reconfigure the workforce to direct more staff in service to frontline and emergency response, making use of retirees and returners to provide 'business as usual' services such as ward rounds, which would create additional capacity. Overall, future resilience in relation to workforce requires a holistic view on capacity, rather than filling specific gaps or roles with skills that are temporarily in short supply.

Key takeaways for leaders

- Recognition is required that total clinical workforce capacity is predetermined and finite, it is therefore important to identify that limited additional productivity and/ outputs can be offered by the current workforce, without running risks related to workforce wellbeing, effectiveness and service recovery.



Workforce

13. Wellbeing

What is the challenge?

With the demand for service provision increasing throughout the pandemic, the wellbeing of staff should be prioritised to ensure the sustainability of the health and Social Care response over the coming months. Organisations should also consider the challenge of making resources available to all stakeholders with a consistent offering, aligned with a recognition that staff wellbeing should be a part of business as usual process, not just a temporary service in rapid response environments.

Impact and Frequency

The wellbeing of staff was recognised both during the first response and on an on-going basis as a key priority in a large number of the documents reviewed. As the response continues, organisations also noted that staff resilience should continue to remain a key focus for NHS boards through response, recovery and remobilisation.

What has worked well in Scotland?

- Teams reported an overwhelming sense of camaraderie which was supported by a number of purpose-built resources. As an example, NHS Grampian introduced a Psychosocial Resilience Hub to support the National Wellbeing Hub. The Board's Director of Psychology has led a multi-disciplinary team to create a 'matrix' of resources available to staff for easy access.
- Many organisations clearly identified the requirement to prioritise psychological support for staff early in the on-set of Covid-19 pandemic. This was delivered through a range of dedicated support streams, working groups and wellbeing facilities. Organisations stated that they had reviewed the offer they had made available to staff during the pandemic to ensure that this was still relevant. Several organisations created new staff wellbeing groups to align with the ever-increasing demand for services.
- A national integrated digital wellbeing hub was developed for health and social care staff, carers, volunteers and their families to access relevant support. The hub is supported by a range of organisations and provides a range of self-care and wellbeing resources designed to aid resilience as the whole workforce responds to the impact of Covid-19.
- Digital mental health services were rolled out by Scottish Government for staff including internet-enabled CBT and psychological first aid. This built on considerable pilots already rolled out in Scotland for the public, for example in NHS Western Isles where a pilot saw a 500% increase in referrals to this service.

Opportunity for further resilience

- Despite numerous organisations highlighting that they felt services provided were sufficient for maintaining staff wellbeing, there were gaps identified in terms of access and range of available tools. Not all bodies had the use of all tools, with a key example being referenced by one organisation as not having, but wanting access to, Listening Services.
- Some organisations also recognised the fact that these resources must be considered as more than just a temporary measure. As the impacts of the pandemic continue to be felt, there is therefore a requirement to embed such services into ways of working going forward. The need for support is likely to increase over subsequent waves and some bodies noted that line managers required additional guidance on supporting staff remotely in rapid response events.
- In line with wider findings around the integration between health and Social Care, Scottish Government will need to ensure that, where new tools are rolled out or services provided, there continues to be equal access for all relevant stakeholder groups.

Key takeaways for leaders

- Recognise that wellbeing response to the pandemic will be needed in the long-term. Leaders must consider how to transition this into business as usual and continue to support the physical and psychological wellbeing of staff.
- Line managers continue to be a source of support to staff. Leaders should consider how to equip managers with the necessary training/resources on how to support staff remotely.

14. Governance and Leadership

What is the challenge?

The challenge, particularly in rapid response environments, is maintaining a level of governance whilst allowing scope for quick decision making. Organisations have drawn attention to the fact that this new way of adopting an agile governance approach could be cascaded into business-as-usual processes to reap the benefits of quicker decision making and increased collaboration.

Impact and Frequency

Many organisations took the opportunity to reflect on changes to existing governance and leadership mechanisms during their lessons identified exercises. As part of this, key comments reflected a desire to embed some aspects of what worked well rather than highlighting significant opportunities for improved resilience.

What has worked well in Scotland?

- There is a collective sense that 'command and control' provided strong leadership across organisations at a time where it was needed. Health and Social care Scotland reflected on this further by describing leadership to be compassionate within partnerships and providing the "backbone" for staff to feel confident about change.
- A key statement referenced by a large number of organisations was the 'authority to act'. Aligning closely with findings throughout this report on governance, organisations noted that leaders at all levels felt empowered to act.
- Several bodies noted that during the pandemic, a change to 'lighter' governance has improved the pace of decision-making. Health and Social Care Scotland highlighted that there has been an increased autonomy within the organisation and teams felt empowered to make change. The organisation also recognised that thresholds to sharing information across organisational boundaries had been lowered thus contributing to the pace of decision-making.
- Participants also reflected on the effectiveness of Covid-19 hubs that provide streamlined care. Health Improvement Scotland commented that the removal of red tape and bureaucracy enabled a rapid response and unprecedented collaboration. Interviewees also noted that Covid-19 had 'forced the agenda' of joined-up working in their local authority and challenged siloes.
- Based on the newly implemented governance at NHS Louisa Jordan, the team involved recommended that daily update meetings should be held in any future rapid response events to ensure all stakeholders are kept fully informed.

Opportunity for further resilience

- Opportunities for improved resilience around the new agile landscape has required a different approach from a management and leadership perspective, namely through the delivery of the leadership development programme. NHS Orkney have stressed that there is an enhanced

Opportunity for further resilience

requirement to equip management with the skills to have coaching and wellbeing conversations with staff during a period of increased self-isolation for some.

- There is also a concern around the recognition that the prevalence of 'command and control' culture setting has involved negative behaviours. The balance between command and control and inclusive, compassionate decision-making will remain crucial over the remaining response to the pandemic.
- The importance of balancing quick decision making with assessing impacts and scrutiny has been referenced by a number of organisations. Having a wider range of decision-makers present (covering operations and clinical teams for example) has been suggested as one way of both speeding up decisions and mitigating unintended consequences.
- Many organisations also noted that responding to the pandemic has required multiple changes to structure, partnerships and delivery groups for both themselves and their partners. As a result, there has been numerous rounds of iterations with multiple new strands of governance groups and committees. Organisations should be sure that any transitions back to previously used structures are appropriately justified and explained to staff members.

Key takeaways for leaders

- It is important for leaders to understand has there always been existing strong leadership skills and approaches within organisations prior to the Covid-19 response.
- Lessons identified around command and control highlights the ability of flexible governance structures that can prove pivotal in a rapid response environment.
- Ensure there is enough representation to counteract unintended consequences of decisions could be considered going forward, for example increased clinical representation in operational decision-making.

Developing New Care Model

15. Service redesign

What is the challenge?

With a pressure for bodies to deliver Covid-19 and non-Covid-19 services, challenges arise around the finite availability of resource. In response to that pressure, we are seeing from the literature review that organisations are utilising innovative solutions to better make use of existing capacity. However, it is important to be aware of the environment in which innovation can be fully harnessed, and that this is aligned with pressures experienced.

Impact and Frequency

Many organisations referenced new pathways or innovative approaches to treating patients as part of their lessons identified from the first wave response. Reflecting on these new approaches will form a fundamental part of recovery and remobilisation plans and identifying lessons and good practice from across Scotland will be crucial over the coming months.

What has worked well in Scotland?

- Multiple organisations referenced the national 24/7 pathway with patients being directed through the 111 service as a key area of success. This provided consistent triage for all organisations by NHS 24 and allowed a seamless pathway to local hubs for further clinical consultation and consistent onward referral for self-management and to other services in the community or Acute setting as required.
- Health and social care organisations also noted that even though they were now commonplace, discharge hubs offered added value during the first few months of the pandemic to support planning for discharge from the point of admission. This was highlighted as being crucial when patients were directed to the hubs early on in their care journey.
- Practitioners have drawn attention to redesign around making better use of resources and patient time, with greater clarity in triaging patients. Navigation was preferred rather than redirection, taking a more patient-centred approach and drawing from the patient's own resources for self-care.
- NHS Ayrshire and Arran felt that the work being done through the new urgent care pathway (to provide the right care at the right place to maintain the lower level of A&E presentations found during the pandemic) as a pilot scheme is working well.

Opportunity for further resilience

- Organisations regularly referenced staff only being able to work jointly across Covid-19 and 'standard' pathways due to the pause on most core activity. This leads to an anticipated tension caused within the system while the Covid-19 and non-Covid-19 clinical work both need to be offered from within the same clinical capacity.

Opportunity for further resilience

- One organisation has also reported that although the turn towards telephone conversations has reduced pressure for face-to-face contact, conversations have taken longer, therefore reducing overall capacity. Concerns regarding the suspension of non-essential services were also raised, recognising that despite the fact face-to-face had to be reduced, there are elements of patient care that cannot be delivered virtually. Note we have not vouched for the accuracy of this statement but recognise one organisation has suggested this may be the case.
- The new urgent care pathway in Ayrshire and Arran has not been supported by a wide-spread patient marketing programme as this risks misleading non-Ayrshire patients. When the pilot extends to the rest of the country, a wider community awareness campaign will support uptake and encourage patients to interact with the system in the desired way.

Key takeaways for leaders

- Service redesign requires statutory consultation with the public and patients, and any organisations looking to embed changes from the Covid-19 response will need to ensure this is managed appropriately.
- Consistent themes across new models of care should be identified and kept in mind as services continue to transform. Regional hubs, targeted patient navigation and the use of digital will remain central to service provision going forward.

5. Follow Up Phase

This section of the report provides a more detailed consideration of three of the chapters included in the previous section. As outlined in the executive summary, these chapters were selected for further work by Health and Social Care Management Board. In each of the chapters below, lead directors and identified stakeholders have shaped the content and approach to the review. The content for these chapters was collated over April and May 2021, still with a focus on the first six months of the pandemic, and should be considered as complementary to, not in place of, the relevant chapters in Section 4.

1. Public Health

Introduction

This chapter focuses on the first six months of the Covid-19 pandemic response from a Public Health perspective. To inform the content of this chapter, key stakeholders across Public Health Scotland and Scottish Government, as well as Directors of Public Health from territorial boards, have been consulted on their reflections on what went well and where areas for increased resilience might be. This chapter summarises conversations held with these stakeholders and distills and identifies key findings from this engagement and further reviews of documentation. The findings below have been shaped predominantly through engagement with stakeholders outside Scottish Government to provide an external view on Government's response, although stakeholders from within Government have been included in all consultations to provide context and input where appropriate.

What is the challenge?

Public Health teams have taken on a pivotal role in tackling the Covid-19 pandemic by helping areas to understand and address the economic, social and psychological impacts of the pandemic and the health inequalities that have been highlighted and deepened. Across all four of the Harms identified by Scottish Government (being direct health impacts, indirect health impacts, societal impacts and economic impacts), there is a central role for Public Health teams at national and local levels to drive the country's on-going response to, and recovery from, the pandemic. The impacts of Covid-19 will therefore need to be continually assessed, including strengthening of mitigations and contingencies through this lessons identified exercise and identification of any further work that may be needed to reinforce Scotland's response to the pandemic.

What has worked well in Scottish Organisations so far?

Key themes:

Finding A: Collaborative working across organisations

Collaborative working across organisations has been highlighted consistently by the public health stakeholders we spoke to as as a crucial enabler during the first six months of the pandemic response. Key examples referenced by stakeholders included:

1. **The National Incident Management Team:** The rapid stand up of a National Incident Management team provided a useful forum for local feedback and intelligence when it came to suppressing the virus. This team provided a forum for shared learning and future foresight as a collective group. To further drive collaborative working, the group made the challenges faced by individual territorial boards more widely visible both to other boards as well as colleagues in government. A key reflection from our conversations with both Scottish Directors of Public Health (SDPH) and Public Health Scotland colleagues was around the evolving structure of this team over the course of the pandemic and that on reflection, stronger connections with DPHs and SG should have been encouraged from earlier on in the pandemic.

Finding A: Collaborative working across organisations

2. **Joint daily huddles:** The creation of joint daily huddles between Covid-19 Public Health Directorate Senior Management Team and Scottish Directors of Public Health was referred to as a valuable asset as a source of cross-functional working which provided not only rapid information sharing and helpful insight into political decision making but also genuine emotional support for individuals. The joint huddles acted as an access point where other Scottish Government Directorates could go to for advice and support of the SDPHs, as well as a means for further input to be provided by relevant Public Health colleagues as necessary. Joint daily huddles have proven to be extremely valuable and it has been suggested that they should be re-introduced at emerging stages of future global health threats and into business as usual.
3. **The use of Local Resilience Partnerships:** Colleagues discussed examples where these structures worked particularly well, as such in the Dumfries and Galloway area where the Local Resilience Partnership brought together local partners to exchange data, share best practice and coordinate the local response. Through this group, communications were coordinated and agreed in advance between Local Authorities, Police Scotland, Fire and Rescue and the territorial board to ensure a joined-up response. The Partnership also supported local universities and businesses through the deployment of local Environmental Health and Resilience Officers to support testing and provide guidance. In contrast, in areas such as the Highlands and islands, this approach was not so successful, however a workshop was held to help identify and mitigate some of the issues faced in these areas during the pandemic.

Two other wider messages were captured under this theme. The first of these was **the importance of the integration of Public Health professionals** into many elements of the pandemic response**.** A key example cited was the role of Public Health professionals being integral to the pandemic response in care homes through the close working of the SDPH group with the Care Inspectorate and within NHS. This went beyond traditional roles and responsibilities in this area and should be considered as the sector moves towards the 'new normal'. Ensuring that Public Health professionals are in the right decision-making conversations will continue to draw on their relevant experience and expertise in any future incidents or pandemics, as well as other expert advice sources. Public Health experts bring viewpoints and expertise not readily available in other teams, and involving them in early conversations and steering groups mitigates the risk of unintended consequences as well as inefficient decision-making.

The final point highlighted under the theme of collaborative working was **strong engagement with the Chief Medical Officer.** We heard of significant engagement from the interim CMO and deputies with SDPH through many of the above case studies such as the joint daily huddles and National IMT. This was extremely valuable and provided opportunity for the SDPH group to influence and understand the developing response to the pandemic.

Finding B: Test and Protect

The design and deployment of **Test and Protect** was also cited as a key theme and a case study in itself by stakeholders. Within Scotland, a comprehensive network of testing sites was rapidly established, which now includes eight Regional Testing Sites, 45 Local Testing Sites, and a fleet of over 40 Mobile Testing Units on rolling deployment. This network is now supporting the roll-out of asymptomatic testing and more targeted community testing to finding cases in identified higher prevalence areas and support targeted local interventions. Public Health teams felt that the work around Test and Protect exemplified what worked well for the Public Health response.

In particular, stakeholders reflected on SDPH and Public Health Consultants and Specialists making a huge contribution in taking on key roles in advising on response to the pandemic including co-development of Test and Protect as a local/ national partnership. This was **a clear example of how to benefit from collaborative relationships between teams at local and**

Finding B: Test and Protect

national level. Specific reference was given to the role of local outbreak control teams as well as local resilience partnerships, who have been able to quickly respond to identified local issues with much more flexibility and pace that might have been possible through a solely national response.

To highlight the importance of local knowledge and insights, stakeholders fed back that the UK Government-wide testing model was challenging at times in contrast to what was being done locally in Scotland. Local Public Health teams reported struggling to navigate a system that they felt was not amendable to adjustment when system failures were clearly evident, e.g. allocation of nearest testing location, national switch off and divergence of testing capacity with little or no warning. This further supports the benefits of the approach taken by teams in Scotland to balance the best of local and national responses.

Finding C: Collective mobilisation

Collective mobilisation was also referenced throughout discussions, making a clear distinction between collective working across organisations and the mobilisation effort within Public Health teams as they currently existed to work in innovative and reactive ways.

1. The first finding was the importance of appropriate **deployment of staff within Public Health Directorates** both across Scottish Government and more widely across NHS Boards**.** As a result of the enormity of the Covid-19 response, practical decisions were made to free-up resource to sustain the response, including the deployment of staff within Public Health directorates who did not have primary health protection roles including health improvement, research and evaluation staff, and specialists from other Public Health fields (dental Public Health, pharmaceutical Public Health and administrative staff) to name a few.
2. Secondly, the unprecedented and rapid **mobilisation of staff** was crucial to what worked well from the response and has resulted in the formation of a large system wide approach to tackling Public Health. This approach has been primarily driven forward through emergency planning structures to mobilise staff across the NHS, Health and social partnerships, Local authority, Police, Fire Service, Scottish Ambulance service and the third sector. This has led to the development of strong collaborative relationships at local level meaning that in the event of future pandemics the relational foundations to plan, prevent and respond are already in place.
3. Another key finding related to the **collaboration between Local and National Public Health.** The Covid-19 pandemic has emphasised the importance of a strong working relationship between local Public Health teams and national Public Health organisations. Public Health Scotland was cited as being critical to many areas, in particular the role of Health Protection Scotland (now Public Health Scotland) in supporting the pandemic response in local boards. This included publication of guidance to support local teams, advice and support on complex situations and attendance at incident management teams which has enabled shared learning. One specific example of local and national collaboration was the co-design and co-delivery of the Scottish Test and Protect Response, which has enabled Scotland to utilise both the benefits of a local response and translate into practice leveraging national co-ordination, surge capacity and supporting infrastructure as referenced above. Stakeholders here noticed a key point of comparison to the English response to the pandemic through the previous abolishment of regional Public Health teams and observatories, which was felt to impact the English response to the pandemic by losing the local knowledge that local teams within Scottish Boards have been able to draw upon throughout the pandemic.
4. Colleagues referenced that the Preparing Scotland for Emergency prepardeness guidance set out a clear process for responding to emergencies, with the central role of SGORR and the creation of a Strategic Coordinating Group, as well as Scientific and Technical Advisory Structures to provide clarity of advice to that group.
5. The final element was the **clear commitment of staff.** Overwhelming willingness, flexibility, and commitment within Public Health teams to design and deliver the response around the

Finding C: Collective mobilisation

clock. Within the SDPH group, position statements were produced to inform key policy areas of the pandemic response, providing weekend cover and informal support for one another. A workbook approach was established which has been further built on and developed, enabled by ScotPHN team. This overall commitment does however raise potential concerns around the sustainability of this response.

Finding D: How data was used to inform the Public Health response

The final theme that came through strongly in our consultations on the Public Health response was **how data was used to inform the Public Health response**, particularly to drive decision-making and provide an evidence base for specific interventions**.** Three key examples were cited to show how data was used, which we have outlined in more detail below:

1. Directors of Public Health referenced the importance of the **National Data Intelligence Network** as a lasting legacy of the pandemic response. This draws on expertise across local authorities, public health and health boards to try build capability in using real-time data to inform decision-making and policy decisions. Interviewees also referenced the importance placed by the network on ethical concerns about the use of data as being central to its on-going work.
2. Patient data was used to measure impacts of Public Health interventions including EAVE-II study which through data linkage of general practice, hospital, testing, prescribing, and death data allowed demographic description of cases and ultimately real life effectiveness of vaccination on hospitalisation, deaths and transmission. The emphasis on impact measurement of Public Health interventions provides an objective basis upon which future interventions can be measured as Scottish Government reflects on potential easing of restrictions and responses to any future incidents.
3. Another example of a data-led approach to Public Health interventions was through the use of **Whole Genomic Sequencing (WGS)**. The Thomson paper has been cited as a key example here, but also evidence through WGS to show the impact of events such as the Nike conference in the lead-up to the pandemic. While colleagues specifically within PHS highlighted how crucial this approach was for the on-going response, limitations were identified around sequencing capacity and scalability. This was reported to have led to significant challenges in the interpretation of the impact of novel strains and the role of domestic cases versus international travel during the first wave of the pandemic.
4. The final example referenced within the use of data through the Public Health response was the effective use of **publicly accessible dashboards** which allowed descriptions by LA, NHS board and All Scotland for tests, cases and hospitalisations.

Opportunities for further resilience in Scotland from the Public Health Perspective:

As with the reflections on what went well above, the engagement exercises held with Public Health teams (predominantly Directors of Public Health and Public Health Scotland, but also within Scottish Government) identified opportunities for further resilience. These examples have been grouped by high level themes, which have been agreed with stakeholders as part of these engagmeent sessions. Key examples have been included within each section to highlight specific areas for future reflection.

Finding A: Pandemic Preparedness

Pandemic Preparedness has been highlighted as a key area of interest to keep under review for future incidents. Specific examples of what might be done differently have been outlined below based on our engagement with identified stakeholders:

Finding A: Pandemic Preparedness

1. **Levels of resource availability** across Public Health in Scotland prior to March 2020 impacted both the initial and on-going response to the pandemic by requiring significant staff overtime. In addition, plans were submitted to enhance the Public Health workforce in June 2020 and the funding letter was not received until November 2020. This caused delays in decision making which created additional pressures on the existing workforce. There needs to be reflection on how Public Health is prioritised as part of a 'whole system' approach going forward. Future workforce planning for Health Protection and Public Health needs to be urgently actioned to allow recovery as if left unaddressed this may threaten the aims and objectives of the evolution/development of public health work in Scotland.
2. Whilst threats such as pandemic influenza and emerging infectious diseases were identified as major resilience threats to the United Kingdom, there was a perceived lack of preparedness from a Public Health perspective, particularly in terms of **PPE provision**. During our discussions with stakeholders, there were concerns raised regarding the absence of pragmatic checks such as checking if PPE was in date and confirming workforce staff levels It is important to note that there was a national stockpile of PPE in place however demand for this was unprecedented, something which could not have been anticipated in previous planning exercises or expert guidance. We note also here that some stakeholders reported that shelf-life monitoring and shelf-life extension through re-testing were planned activities for existing stockpiles.
3. Neither Health Protection Scotland nor Public Health Scotland had **formal Category 1 responder** status which should be addressed in the future to recognise their key role in responding to emergencies/Public Health incidents of concerns. Stakeholders have noted that individual public health teams are hosted by NHS Boards which are category 1 responders, which ensures there is local public health input into incident response. This status has not been extended to Public Health Scotland however, although stakeholders noted that a review of roles and responsibilities for category 1 responders could determine the need for this going forward.

Finding B: Challenges faced when communicating

A second key area for increased resilience related to **challenges faced when communicating** within and outside Scottish Government and Public Health organisations.

The first of these related to the **timing of communication.** Colleagues felt that there were occasions when Scottish Government guidance was issued which either contradicted or did not align with Health Protection Scotland guidance, and that this caused significant stress and confusion to local teams on the ground. This was exacerbated when several aspects of guidance were felt to be 'piecemeal' in collections of letters, often sent out late in the evening or over the weekend with immediate implementation required. The risk that much of this got lost was significant given the workload already facing local teams. There is a recognition from colleagues that there are other demands that led to the publication of guidance at these times, but further, early engagement across organisations could mitigate this

Secondly, colleagues referenced a perceived **duplication of efforts internally within Scottish Government.** For those working outside Scottish Government, there was a sense of multiple SG teams working on the same topic with little internal communication, leading to multiple similar demands being made to boards which were perceived to be of little added value. Subsequent engagement with Scottish Government highlighted that structures may have been later clarified and communicated, and therefore a key learning from this first phase of the response will be to formalise and more widely communicate this structure to reduce any further duplication.

Finding B: Challenges faced when communicating

Stakeholders referenced a **lack of alignment** between organisations involved in the pandemic response when issuing communications. Specific findings that were felt to evidence this lack of alignment include:

1. SDPH and both local and national Health Protection teams were reported on occassions to not be aware of policy announcements before they happened which led to teams both nationally in Health Protection Scotland and in local boards being on the back foot. However, SG colleagues highlighted the challenges with pace of decision-making and role of government to respond to the unique circumstances of the pandemic.
2. Stakeholders felt that a lack of opportunity to be engaged or work through challenges in conjunction with partners risked unintended consequences or implementation challenges where public health insight was not provided at an early stage.
3. It was reflected by colleagues that SDPH felt they were generally not encouraged to support the national communication effort, giving rise to the view that Scottish Government wished to control communications. This has been viewed as a missed opportunity to allow the voices of trusted local leaders to support the effort. Stakeholders however did recognise that there are benefits to having a single, clear national voice, and that this could be supported by trusted local leaders within their local areas.
4. Stakeholders noted one result of the perceived lack of alignement and delay in commuications was felt to be a delay to confirmed funding for public health teams on Test and Protect. Teams reported that this delay led to significant pressure on the existing workforce and a prolonged period of catch up to train and recruit new staff.

The final element of communications reflected on throughout our engagement has been commentary on the perceived **tone of communications issued during the pandemic.** During our conversations with colleagues, it was raised that whilst unintentional, the tone of communications and conversations with local teams was at times overly directive and was too heavily influenced by a command and control approach to communications. Stakeholders recognised that this is a delicate balance given the clear need for direct, national communications during incident responses. This resulted in expressions of gratitude and appreciation given at other times being felt as insincere.

Finding C: Centralisation of decision-making and levels of governance

Another key finding raised throughout this engagement with Public Health colleagues, which echoed findings from the first phase of work, was around the risks associated with the **centralisation of decision-making and levels of governance**. Specific examples within this that were highlighted to us during this work included:

1. **Levels of document sign-off** for new guidance was seen to impact the pace of delivery and dissemination. The obligation of a requirement for guidance document sign off by Scottish Government, although critical, often led to clinical risk as this was a slow process. Regardless of agreed streamlining of requirements, this process has continued be challenging for the delivery of updates and issue of new guidance for the NHS. We note here that the role of SG is clearly defined in response to major incidents, particularly with reference to the 2017 incident guidance, but it is important that this is considered against the pace at which changes can be made.
2. **Siloed ways of working:** There were a number of programme boards created at national levels. This was felt to lead to overlap and also inadvertently promote ‘siloed ways of working’ across key themes (i.e. separation of test and protect and self-isolation support). This then was reported to give rise to slow decision making and lack of clear communication for those areas by virtue of a perceived over-centralisation of governance away from local organisations. In addition, the SG Covid-19 Advisory Group was reported to have not included

Finding C: Centralisation of decision-making and levels of governance

representation from those working at the Territorial Board front line of the Public Health response. This was seen by colleagues as a crucial perspective that was missing from this important advisory group, although it is accepted that the group was established to consider scientific, and not operational, factors.

3. In addition to this siloed working, colleagues also felt that there were attempts to **over-centralise decision making** and delivery models without consultation with local SDPHs. It will continue to be important in the future to recognise the crucial insights that SDPHs can bring from their local geography and population needs, with examples cited as vaccination in Island Boards and imposition of Service Now when local delivery models were working well. As with sign-off and communications points previously raised however, it is importance to recognise that Scottish Government is mandated by incident management guidance to make key decisions here which limits the extent to which significant consultation could be undertaken.
4. This reported over-centralisation and lack of formal engagement with Public Health led to a feeling that **roles and responsibilities could have been allocated to Public Health** directors, recognising they could offer a valuable perspective across the range of the 4 Covid-19 harms. A key example cited here was the fact DPH advice was channeled into Harm 1 (direct health impacts), meaning that input into other areas of harm such as inequalities and determinants of health were not sought.

Finding D: Consistency of systems across organisations

The final area for potential increased resilience highlighted was the **consistency of systems across organisations**. This is in line with some of the findings from the first phase of work where consistency of digital support across different teams has been highlighted as a challenge, and Public Health colleagues were able to provide additional examples of this below:

1. Stakeholders highlighted that **the lack of a common incident management system** impacted the effectiveness of the early pandemic response. Stakeholders noted that while NHS Boards had used one system prior to the pandemic (HP Zone), Public Health Scotland only had a 'summary view' to this system due to restricted control by the thrid party provider. This limited the extent to which national management and analysis could be carried out and NHS Boards were not in control of access to important data due to this external licencing arrangement. Future prepardness would be supported by ensuring that commissioning arrangements for IT projects include appropriate governance arrangements to ensure NHS Boards have unrestricted access to clinical data held on their populations which could be accessed as and when required especially in an emergency situation.
2. **Standardisation and use of a single technology system** across public sector teams to facilitate home working was seen through the implementation of MS Teams, this has been viewed by colleagues as a real strength that has been accelerated as a result of the pandemic. There was an important point around improvements needed in broadband width across Scotland and for colleagues working in Scottish Government to allow use of cameras on Teams as connecting with faces would help to build relationships and trust with individuals meeting for the first time in highly stressful circumstances.

Key Takeaways:

- **Workforce planning:** A key element of any future pandemic response is felt to be a well-resourced Public Health system with the right level of skills and expertise nationally and locally. This would include the ability to have a robust contact tracing service at both local and national level, an area which was highlighted that had not been addressed following previous pandemic exercises in the recent Audit Scotland report. In addition, a workforce plan for Public Health is felt to be urgently needed. Health Protection Scotland felt under-resourced to mount

Key Takeaways:

a sustained response to the pandemic even with suspension of as much business as usual and temporary deployment of staff from within NSS and secondment from Universities and limited NHS board secondment. As the pandemic response continues and future incidents are reviewed, an understanding of current gaps, and a pipeline for how to mitigate these gaps should improve pandemic preparedness.

- **Agile ways of working:** Public Health is a complex and adaptive system, relying very heavily on local relationships built up over time. The importance of this cannot be overestimated and whilst unwarranted variation is not helpful, the ability to adapt to local situations and circumstances is vital. There must therefore be a recognition that Scotland-wide approaches can be helpful but not for everything. Development of better systems to collect feedback from and engaging with sectors and communities in relation to impact of restrictions applied is something that warrants further consideration.
- **Value of Public Health:** The response to the pandemic reaffirms the critical importance of Public Health expertise both locally and nationally and the need to use a system wide approach to address not only future pandemics, but to improve the key determinates of health that fuel inequality, long term health conditions and premature death. Local and national systems are energised by way they have managed to respond to the pandemic and bring this learning to other areas which threaten population health.
- **Future preparedness:** Whole systems approaches are required to tackle both this pandemic and any future incidents. Public Health Scotland has already begun several pilots looking at the Public Health Priority areas using a whole systems approach. There will be an opportunity to refresh these pilots considering the Covid-19 learning rather than directly picking these back up where they left off. It is critical that SDPH and local Public Health teams work together with PHS and key partners to co-create and design these whole systems approaches, just as they have done for the Covid-19 pandemic. Further evaluation and development of a unified incident management system for PHS will be important in the short and medium term. In addition, regular modelling of plans for managing of novel viruses with learning should be implemented with all aspects of the system involved to plan for future major incidents.
- **Governance for a future pandemic response:** Governance for a future pandemic response must be considered and reviewed considering the lessons identified from this wave of the pandemic. This could include implementation of a National Incident Management Team with strong connection to local DPHs and SG much earlier in the face of a pandemic. Government, PHS and Local DPHs, and Health Protection colleagues must have involvement in this with clear decision making and communication channels established and communicated to national and local Public Health systems, with a forewarning approach were possible to allow for implementation to happen efficiently.

2. Acute response

Introduction

This chapter specifically focuses on the first six months of the Covid-19 pandemic from an Acute response. Findings have been informed by engagement with key representatives from NHS Scotland and Scottish Government including the Chief Executive, DPAD Senior Team members, Deputy Chief Medical Officer, Chief Pharmaceutical Officer, Chief Nursing Officer, Head of Scheduled Care and leads from Territorial and Special Health Boards. In holding one-to-one interviews, group sessions and reviewing provided documentation, this chapter seeks to gather reflections on lessons identified with the view to facilitate planning for future waves or incidents, as well as broader recovery.

The scope of this chapter has been agreed with these key stakeholders as providing an illustrative answer to the three questions below. This is not seeking to be a definitive answer given the methodology taken and the time constraints facing those consulted during the process.

1. How was the NHS Acute sector set up to respond to the initial wave?
2. How well were services stood back up through the remobilisation of the NHS?
3. How well were services adapted/changed due to the challenges and opportunities of Covid-19?

In this chapter we frame the examples of what worked well and what the opportunities for increased resilience might be around these three questions.

What is the challenge?

The Covid-19 pandemic has highlighted the need to address NHS Scotland capacity and resilience and emphasised the need to change the way things are done within the system. Existing challenges faced around productivity, workforce and integration have been exacerbated by the pandemic, with concerns about the potential long-term impact on staff wellbeing and the challenge of continuing to operate Covid-19 services whilst restarting routine services. It will be important that the learning and perspectives of key stakeholders are reflected upon as both Scottish Government and NHS Scotland move into the next phase of the response to Covid-19.

What has worked well in Scottish Organisations so far

Question 1) How was the NHS Acute sector set up to respond to the initial wave

A significant amount of feedback focused on this first question. We have grouped these into four key themes below, with specific examples and further narrative included within each of those themes to outline what was done and why this worked well.

Finding A: A rapid reconfiguration of Acute provision

1. **The role of National Services Scotland (NSS) in distributing PPE**: The central co-ordination by NSS was found to be vital in supplying the health and Social Care sector with PPE throughout the pandemic. Such was the effectiveness of this that the NSS' remit was extended to include distributing PPE directly to General Medical Services, such as GP surgeries and community pharmacies, and Social Care settings, including private providers. From April 2020, NSS established 48 regional hubs, where PPE was stored and distributed to Social Care providers and unpaid carers. Between March 2020 and January 2021, NSS had distributed more than 800 million items of PPE to health and Social Care services throughout Scotland. This central management of PPE was felt to achieve significant efficiencies with regards to the distribution approach and should be highlighted as a clear example of what worked well for the Acute response. As noted in a recent Audit Scotland report on PPE, there has been an increase in the volume of PPE being created within Scotland as the pandemic has continued, mitigating the risks of relying on global supply chains while also creating jobs in Scotland.
2. **The repurposing of medical equipment:** In the early stages of the pandemic, prior to March 2020, data modelling was carried out suggesting a significant shortage of ventilators, with capacity forecast to exceed in the short-term. During interviews, all stakeholders commended the huge efforts from teams, particularly those in medical physics, who worked around the clock to repurpose hundreds of medical theatre machines to turn them into ventilators whilst elective procedures were at a standstill. This bridged the gap until the first ventilators arrived and mitigated the risks involved in sourcing from a global supply chain during a pandemic.
3. **Maintaining performance for cancer services:** Cancer service performance was maintained throughout the pandemic, with many boards continuing to meet the 31 day cancer decision to treat to treatment standard. Performance against with 62 day cancer referral to treatment standard remained steady despite many diagnostic services such as endoscopy being paused for all but essential procedures. This was due to NHS boards continuing to prioritise urgent and cancer services while scaling back elective activity. This was supported by the new clinical prioritisation guidance and the Framework for Cancer Surgery published in July 2020 and use of independent hospitals to treat urgent NHS patients. There was an initial reduction in referrals with a suspicion of cancer from Primary Care and the daily Covid-19 press briefings were pivotal in responding to this where the Scottish Government's Interim Chief Medical Officer and National Clinical Director were able to remind the general public that the NHS remained open for anyone experiencing urgent symptoms including those suspicious of cancer. Referrals for suspicion of cancer returned to pre-Covid levels in August 2020.
4. **Creation of surge capacity:** Resilience of the system to respond through reorganisation of local services was achieved through re-provisioning of Acute beds (approximately 3,000) and quadrupling the base number of adult ICU beds (from 173 to 585), within a short period of time. This acted as an important safety net for Covid-19 related hospital admissions. There is a need for boards to continue contingency planning, including the ability to scale ICU capacity, as required recognising that, this may be affected by other pressures in the future, such as increasing emergency department attendances, staff absences and enhanced infection control requirements.
5. **Stand up of NHS Louisa Jordan:** The NHS Louisa Jordan, was set up in under three weeks and was operational by 20 April, with an initial capacity of 300 beds, and the ability to expand to 1,036 beds if needed – including 90 intensive care unit (ICU) beds. In the early days of the pandemic it was used for outpatient appointments and for diagnostic services such as X-ray and ultrasound. During the early chapters of this report, colleagues reflected on the success of the multi-disciplinary effort to stand up the NHS Louisa Jordan during the height of the first response.
6. **Clinical prioritisation:** As planned care resumed the Scottish Government sought to support NHS Boards to prioritise those patients who require to be seen and treated most urgently.

Finding A: A rapid reconfiguration of Acute provision

This would ensure that the build-up of patients waiting for elective care was tackled on a priority basis wherever possible. To do this the Scottish Government put in train plans to develop guidance to support NHS Boards to assess how a process of 'scoring' patients based on their clinical priority could be developed but which would also allow for flexibility to reflect local circumstances. This work started during the period covered by the report although was brought to a conclusion in October/November 2020 with the publication of the *Framework for the Clinical Prioritisation of Elective Care.*

Finding B: Flexible supply of, and support for, the Acute workforce within and across organisations

1. **The re-registration of retired healthcare professionals:** Discussions with representatives from different healthcare professions highlighted that there was variable success in bringing staff back onto relevant registers. In terms of nursing staff, an accelerated recruitment portal with the NMC register was open to anyone who had recently retired, and good work was completed in co-ordinating individuals through the pre-employment checks, with over 16,000 expressions of interest. A key lesson which has come from this is around not being able to place these staff, there is a need to have a much closer relationship with boards in terms of the recruitment process.
2. **The flexibility and use of local 'mutual aid':** We found evidence of early discussions around mutual aid through directors' letters released in the early stages of the pandemic. The volume of staff that was used in the short-term and for Community Treatment and Care Services to ensure separation between those who might be Covid-19 positive took up a huge amount of resource. With the pauses implemented on identified elective procedures, interviewees referenced how local teams worked collaboratively to supply staff, resources or physical space for any urgent requirements without ever meeting the full requirements of mutual aid. Performance leads were reported to have worked well together to identify escalating areas of concern within local areas, with subsequent redeployment of staff or equipment to mitigate this being implemented prior to resorting to formal mutual aid.
3. **The step change in staff wellbeing support:** Another area which was highlighted during our interviews, from a nursing perspective, was the work that the Mental Health team in Scottish Government did on wellbeing for staff. Examples of this included the National Wellbeing Hub, and a mental wellbeing support line available 24/7 through NHS 24. It was noted that this took some time to set up but has helped to keep staff at work by supporting staff and taking their concerns seriously and was felt to have contributed to staff sickness rates being lower than anticipated. This was also highlighted within individual boards, with the move away from a 'traditional' health and wellbeing offer that focused on health improvement became more focused on wellness was cited as being a key positive to retain beyond the pandemic response. As an example, NHS Ayrshire and Arran implemented a revised offer that focussed on wellness networks, psychological support and safety, and the opportunities for reflective practice and compassionate leadership and will look to continue this following positive feedback during the pandemic response.

Finding C: A shift to manage demand for non-urgent services away from acute sites

1. **Collaborative/ integrated working to support Acute providers.** There was a requirement set out in May 2020, for close working between local (Local authorities and Integration Joint Boards) and national level (National health boards) to ensure a whole system response, to ensure that local people were seen and treated in the right place, by the right person at the right time. With regards to cancer services, there was a strong message from colleagues around collaborative working between Scottish Government cancer teams, engagement with

Finding C: A shift to manage demand for non-urgent services away from acute sites

cancer management teams in boards, gaining access and support from ministers and the further benefit of remote working with improved IT infrastructure which enabled capacity for meetings and communications. Whole system working was encouraged throughout and the Winter Planning and Response Group (WRPG) included health and Social Care colleagues in trying to cement relationships which previously had barriers. There was a reflection that perhaps the key takeaway from the pandemic to date was the importance of quickly establishing teams with sufficient breadth of knowledge and experience to react speedily and constructively to challenge.

2. **The role of community pharmacy:** The arrival of the pandemic had an immediate impact on the community pharmacy network across Scotland, as it remained the only Primary Care NHS service to remain fully accessible to patients and members of the public, while providing an almost full range of pharmaceutical care services. The volume of prescribed and dispensed items increased by more than 50% over the last two weeks of March 2020 with workloads remaining increased into May 2020. A notable initiative to ease bottlenecks in the community was the **rapid roll out and access to the Emergency Care Summary system** to community pharmacists, providing access to medication and adverse reaction information and therefore will have reduced the number of telephone calls to general practices seeking information. In addition, July 2020 saw the launch of the national **'Pharmacy First'** service to enable patients to access a wide range of enhanced minor ailment support provided by community pharmacists, this initiative encouraged GP practices and wider multidisciplinary teams to work together with community pharmacy in their cluster to support and enable shared learning and approaches to local pathways which best meet the needs of their local populations.
3. **Medication supply for care homes.** From a pharmacy perspective, there was an important balance between being prepared for a Covid-19 outbreak in a care home and protecting the medicines supply chain to ensure fair access to palliative care medicines for everyone in Scotland. Key examples of how the set-up of the sector was managed well included:
    - Close communication with national procurement was essential to help protect the medicine supply chain across primary and secondary care, especially as two of the essential palliative care medicines are also used in ITU.
    - Care homes were not legally able to stock ward medicines therefore, the details of how the 'pandemic exemption' could help support timely and appropriate access to palliative care medicines was explored by a short life working group, with specialist advice from the Scottish Palliative Care Pharmacists.
    - In addition to the above work, the short life working group developed a piece of work on how to safely repurpose medicines and the Scottish Government Coronavirus palliative care toolkit which described different approaches that Health Boards could adopt, to support timely access to medicines during the pandemic. For example, information about care homes stocking ward medicines specifically for the symptoms of Covid-19.

Finding D: Rapid establishment of oversight and governance structures

1. **Establishment of a network of Covid-19 directorate hubs:** The Scottish Government established a network of Covid-19 directorate hubs, with a workforce of staff redeployed from other departments across the government while wider Government business transitioned to focusing on pandemic response, which was coordinated through covid hubs. There was good oversight and regular communication across the NHS and Integration Authorities (IAs) from the Scottish Government for the acute response. In addition, NHS boards revised their governance arrangements during the pandemic with some reducing in size or suspended subcommittees, while maintaining close contact with the Scottish Government and their local partners.

Finding D: Rapid establishment of oversight and governance structures

2. **Communication:** Stakeholders noted that information systems, in the form of daily assessment of Sitreps from Boards were established to react to the pressures of the pandemic, giving as much detail as an hour by hour overview, with three times a day reporting to ministers. Those consulted also noted that engagement in terms of mobilisation planning was good, it allowed for the setting of expectations and discussions around blockers which acted as a very important forum for boards.

Question 2: How well we stood services back up through remobilisation of the NHS?

Finding A: Remobilise, Recover and Redesign

Stakeholders referenced the value of creating a strategic framwework through the Remobilise, Recover and Redesign (3Rs) document as issued in May 2020, as well as the different ways in which bed capacity was increased for remobilisation despite the constraints of Covid-19 protocols.

1. **Remobilised/phased return:** In May 2020, the Re-mobilise, Recover and Re-design document was published which recognised the importance of building upon the positive changes introduced to date during the pandemic, particularly around the use of digital technology to enable more people to have more of their care at home or in the community and to imbed integrated approaches to delivering health and Social Care support. This document created a good governance structure and set out the assumptions, principles and objectives of safe and effective mobilisation. The framework was clear about rebuilding the NHS differently, with key ambitions described including: developing new priorities for the NHS based on engagement with staff and the public, achieving greater integration, recognising the interdependencies between health and Social Care services, providing more care closer to home, minimising unnecessary travel and reducing inequality and improving health and wellbeing outcomes.
2. **The reconfiguration of primary and community care.** The set-up of these hubs and assessment centres played a key role in protecting the Acute sector during the pandemic by supporting the whole system through triage of Covid-19 cases away from general practice and A&E where clinically appropriate. From March 2020 up to January 2021, over 250,000 consultations for advice or assessment were conducted through these hubs and centres. There was a letter issued in June 2020 asking for continued support with flexibility and capacity within the workforce to staff these hubs and assessment centres. Staff worked together across Acute and primary care, in partnership with NHS 24 and the Scottish ambulance service, to protect communities and reduce the rate of infection, through early identification, testing, triage and treatment of patients showing Covid-19 symptoms, presenting to the hubs and assessment centres.

Finding B: Management of bed capacity

Stakeholders discussed the flexible use of bed capacity across Scotland to enable increased recovery of elective services. Specific examples of this included:

1. The use of local **'mutual aid**' across Boards and the ability to switch resources across Health Boards e.g. Lanarkshire being supported by Forth Valley. Stakeholders reported that while there were national conversations around mutual aid, local monitoring arrangements, particularly within performance teams, were effective at pre-empting potential issues and working flexible to resolve problems locally, rather than resorting to formal mutual aid arrangements.

Finding B: Management of bed capacity

2. The use of **NHS Golden Jubilee** for urgent electives and cancers, diversion of emergency admissions to neighbouring hospitals, for specialist services use of facilities in other national tertiary units. Examples cited by stakeholders for the considerable impact of NHS Golden Jubilee include the fact twenty heart transplants took place under COVID-19 restrictions, against a 'normal' annual case load of around 14; the ophthalmology unit was opened and productivity was maximized to a point previously not anticipated until 2034 in previous plans; two theatres have been opened years before they were anticipated to be; and overall productivity is reported as being at 110% of pre-COVID levels.
3. The pivot and re-focusing of the aims of NHS Louisa Jordan, offering training and other opportunities for diagnostic work. This included over 31,000 outpatient appointments and diagnostic tests including CT and ultrasound, being undertaken at the hospital; 6,930 staff had training and education sessions at the site; as well as supporting the vaccination programme by storing the required equipment in fridges and freezers, 175,000 vaccinations were delivered to NHS staff and the general public; 541 people attended at Blood Donor sessions. We note here that while the beds were not required for their original intended use, stakeholders noted potential concerns about staffing availability for the high acuity, COVID-19 clinical model first anticipated for the LJ. The refocus towards outpatient, diagnostics and other work mitigated these risks by drawing on readily available staff and equipment.
4. Another key finding in relation to how bed capacity was managed was through the use **of the independent sector:** Stakeholders highlighted the crucial role played by the independent sector in the first phase response to the pandemic. In addition to providing additional physical capacity to permit secure sites (i.e. green sites) for non-Covid-19 procedures, the independent sector also provided an additional of qualified staff to be able to support the national response. Stakeholders noted that NHS consultants were able to be rostered into the independent sector flexibly to allow for additional use of capacity. Arrangements were in place by April 2020, reflecting the pace at which both the sector and the NHS itself was able to mobilise in response to the pandemic to provide additional capacity and staff.

Question 3: How well did we adapt services to respond to challenges of Covid-19 and opportunities to change?

Two key examples were cited regularly: the redesign of urgent care, and the way in which digital tools have been incorporated into Acute care. Stakeholders also discussed the adoption of initiatives such as a wider rollout of patient-initiated follow-ups across Boards to be able to manage the back-log of cases in a more effective way.

Finding A: Redesign of Urgent Care

The redesign of urgent care was a unique approach taken by Scotland and was felt to provide a 'significantly transformational approach' to how urgent care services could be delivered in Scotland. The main aim of this was to design a system to deflect people turning up in the emergency department, minimising the risk of spreading hospital acquired infections. This redesign worked well to relieve system pressures which leveraged whole system thinking and integration and was seen as a massive achievement to be set up in such a short space of time.

Launched in December 2020, the redesign of urgent care aimed to provide urgent care as near to the home as possible through two key mechanisms: promoting NHS 24 as the preferred initial contact for carers and the creation of local Flow Navigation Centres with rapid access to senior decision makers. This was piloted in NHS Ayrshire and Arran prior to the national rollout.

Early evaluations have shown that against a benchmark of September/October 2020, all fourteen territorial boards showed a reduction in ED attendances and self-presents, with eleven boards

Finding A: Redesign of Urgent Care

seeing an increase in activity on NHS 24 in hours during the week. An evaluation outlined that while the causality behind changing behaviours is hard to assess, this new approach may be contributing to up to a 5% reduction in all ED attendances. There is also a key consideration taken for patient experience as Health Improvement Scotland are being engaged to ensure that the experience is standardised nationally where possible. Early themes identified from this review of experience show that patients feel safer, report reduced unneccesary admissions and have been able to get more direct access to medical specialties.

Finding B: Use of digital engagement

Embracing technology has allowed care to be delivered even when face to face consultations were not possible across secondary and primary care. As part of the early response to Covid-19, Near Me was scaled up by Feb 2020 and available to almost every hospital and GP practice in Scotland. Prior to March 2021, 336 digital consultations were taking place each week, which increased beyond 17,000 per week by June 2020. Through this increased use of digital engagement (Near Me), there was a reduction of more than 600,000 outpatient attendances in secondary care at this stage. This dropped to over a million outpatient appointments managed digitally in Scotland by the end of the year. In general, people's experience of Near Me was good with over 98% saying they would use the service again, and reasons for this included: its offering of choice of how to access services; and coverage of a wide range of services, ranging from addiction services to wheelchair servicing. Also, an accelerated rollout of new technologies was supported by the Modernising Patient Pathways Programme for scaling up of Colon Capsule Endoscopy and Cytosponge supporting increased diagnostic capacity for patients.

There was a rapid and co-ordinated response by national partners in the design of processes for digital remote monitoring services which has enabled, for example, the protection of women during pregnancy using both blood pressue and urinalysis remote monitoring with Near Me consults.

Digital Health & Care Innovation Centre undertook work alongside partners to repurpose digital tools to support rapid scale up of these throughout Scotland.

The University of Oxford conducted an evaluation of the Attend Anywhere / Near Me video consulting service during the pandemic across 7 local territorial Health Boards in Scotland which discussed, in depth, the reasons for the adoption and use of Attend Anywhere and its relatively limited uptake to March 2020.

Stakeholders also referenced the public and clinical engagement work by the Technology Enabled Care team within Scottish Government in September 2020. This saw the views of 5,400 individuals covering service users and the general public more widely being sought to understand the barriers and potential for video consulting and to identify potential areas for improvement. Specific groups (such as individuals with disabilities and English as an Additional Language) were also consulted to ensure their views were captured as part of the co-design approach.

Finding C: Embedding transformation and change of acute care

The new Centre for Sustainable Deliver was established to support the changes in working in the acute sector during the pandemic. Hosted by NHS Golden Jubilee, it will work with established transformation programmes such as patients safety programme and work led by Health Improvement Scotland to support the recovery plan. It also supports the ambitions of the Redesign for Recovery framework and will play a key role in underpinning the delivery of the Recovery Plan.

Opportunities identified for further resilience in Scotland:

In this section, the chapter goes on to consider the same three questions as above with a focus on what might be done differently in future. Key themes and examples have been cited below each of the three question as raised through interviews and reviews of existing materials.

Question 1: How did we set up the NHS Acute sector to respond to initial wave?

Finding A: PPE stockpiling and early supply

The NHS supported care homes by sending resource, testing and providing PPE supply from its own stock. There is a lesson around having whole system preparedness planning and the need to improve the distribution network in the early stages of the pandemic which was the basis on which many of the initial glitches around delivery of PPE to where it needed to be delivered arose. Stakeholders recognised this during the early pandemic and have already taken steps to mitigate the reoccurrence of this, which should remain part of future planning and preparedness exercises. A key driver of these glitches was felt to be the lack of certainty over who had responsibility for the provision of PPE to the social care sector prior to the intervention of NHS NSS and Scottish Government. It is important to note that Scotland never at any point ran out of PPE proving the resilience of the processes in place, and NHS NSS were able to supply both NHS England and NHS Wales as part of the mutual aid arrangements. There has been huge global demand for PPE since the start of the pandemic. Based on expert advice, The Scottish Government had a pandemic PPE stockpile in place and planning based on an influenza pandemic, as part of a UK-wide approach, but the PPE requirements during the Covid-19 pandemic were unprecedented. For example, in February 2020, NHS NSS shipped 96,911 items of PPE weekly, however by April this figure was 24,496,200 weekly. Stakeholders also discussed whether a more robust system for testing the appropriateness of existing stockpiled equipment, as stockpiles in place were retested to be confirmed as appropriate for current use when required during the pandemic. While managing on-going stockpiles, it will be important to ensure that these are both the right volume and types of equipment in future emergency planning.

Finding B: Overall preparedness

As described in the Audit Scotland NHS 2020 report, the Covid-19 pandemic was caused by a new virus with unknown characteristics. Initially, there was insufficient evidence internationally to show how the virus behaved and was transmitted, who was at risk and what the incubation period was. The Scottish Government had a range of guidance and plans in place to provide a flexible and effective reponse to the Covid-19 pandemic, which was informed by the 2011 UK Influenza Pandemic Preparedness Strategy. Progress in implementing the actions identified during these pandemic planning exercises had been slow. The Scottish Government set up the Flu Short Life Working Group in 2017, which set out priority actions following the recommendations from the Silver Swan and Iris exercises. While the exercises conducted were not in preparation for the specific type of pandemic that arose, some of the areas that were identified for improvement became areas of significant challenge during the Covid-19 pandemic and had not been resolved prior to the on-set of the pandemic.

Finding C: Stepping down of services

Stakeholders commented on the extent to which services were stepped down as part of the initial response. Early modelling and uncertainty around the impact of Covid-19 on Acute sites led to a pause on elective procedures to mitigate the identified risks around Covid-19 capacity. While this permitted the required scaling up of Covid-19 services, the longer-term impact and harms created by the pausing of all services has led to issues with clearing backlogs and residual clinical risk.

Finding C: Stepping down of services

Interviewees suggested that for either future waves or incidents, a 'stepped-down' approach to pausing work might mitigate the problems now being faced with recovery. A review of specific specialties for outpatients, diagnostic services, or day case surgery, that might be able to continue could be driven by a set of objective criteria against each individual services could be measured. These criteria could be developed as an action during the recovery and remobilisation phases of work to increase preparedness for future waves and/or incidents.

As part of this stepping down on services, those interviewed highlighted the example of strong cancer performance as a potential area for additional reflection. It is important to note that although these performance metrics remained high throughout the pandemic, many cancer diagnoses have been delayed and potentially missed. During interviews, stakeholders reflected on evidence that has since been produced, suggesting that, in hindsight, more treatments such as Systemic Anti-Cancer Therapy could have been administered as the risk from Covid-19 was subsequently found not to be as high as initially thought.

Finding D: Mobilisation of new resources and staff

While stakeholders have recognised the considerable efforts and success managed through the rapid recruitment of additional staff and the standing up of NHS Louisa Jordan above, they have also identified potential areas for increased resilience. Interviewees referenced a potential lack of clarity of the purpose of both exercises, with examples being a large number of recently retired professionals ultimately not being required to re-join the NHS, and the NHS Louisa Jordan being repurposed for other services. While colleagues noted the uncertainty around the impact of Covid-19 as being a key driver for these precautions being taken, a future lesson learned would consider how best to develop options for alternative uses of staff, with clear triggers and routes for scaling up and/or down resources for different uses prior to commissioning. A phased approach in both cases might lead to more efficient outcomes in future incidents, with further clarity on the purpose of these exercises providing a more appropriate estimate of the total actual requirement (be this for staff, beds or other resources).

Question 2: How well we stood services back up through the remobilisation of the NHS?

Finding A: Clinical risk around backlogs and waiting lists

Throughout the pandemic, there were concerns that people with symptoms and conditions unrelated to Covid-19 requiring urgent attention, such as heart attacks, would not seek the help of the NHS. In addition, **concerns around pauses in national screening programmes** that may cause delayed or missed diagnoses of cancer and fewer referrals have been seen for outpatient appointments and mental health services between April and June 2020. The longer-term impact is yet to be determined and despite considerable efforts and the launch of 'NHS is open' campaign in April 2020 by the Scottish Government, to persuade people to access services, there was a hesitancy from a portion of the general public to seek non-Covid 19 healthcare treatment. A&E attendances increased between April and August 2020 but started to decrease again from September as Covid-19 cases started to rise. The percentage of people who said they would avoid going to GPs or hospitals decreased from 45% in April 2020 to 27% in October 2020. The Scottish Government and NHS boards need to continually monitor this and take action to mitigate any adverse impacts as a result.

The need for rapid review and management of the backlog of patients waiting for planned care applies across the board but will be particularly critical for urgent patients who have been paused for diagnostic endoscopy or radiology investigations. This backlog review process needs to be set within a context of active clinical prioritisation and a recognition of the impact of continuing use of PPE and enhanced Infection Prevention and Control requirements on service and workforce

Question 2: How well we stood services back up through the remobilisation of the NHS?

Finding A: Clinical risk around backlogs and waiting lists

capacity. Interviewees also referenced challenges with **referral management** with primary care teams referring patients without certainty over how long that patient had been on a waiting list.

Finding B: Tolerance for risk as part of remobilisation

There were a number of challenges in resuming the full range of health services and bringing capacity back to pre-Covid-19 levels. These included: the need to physically distance – meaning operating theatres, clinics and waiting rooms cannot be used to their full capacity; more time needed between appointments; and procedures for replacing PPE and cleaning and management of ongoing cases of Covid-19, which is also continuing to be very resource intensive. When colleagues discussed the 'risk appetite' of services to continue and how these might be delivered effectively, there is a recognition that the lack of knowledge about the impact that Covid-19 might have on services made this difficult and led to risk-averse decision making. Now that there is more knowledge and awareness of the impact of the virus, organisations may wish to reflect on the levels of risk that might be appropriate when assessing the backlog of patients against the need to continue with full Covid-19 protocols within Acute settings.

Finding C: Strategic use of national assets

The clear role for national assets such as NHS Golden Jubilee and NHS Louisa Jordan has been demonstrated while Scotland recovered from the first wave of the pandemic in 2020. Interviewees referenced a collegiate process through which the role for these resources was defined over time. While this brought benefits, the time taken to ensure all parties agreed on the use of these assets. NHS Golden Jubilee has been cited as a clear example of this, with uncertainty about whether or not the site would be a 'green site' or which pathways and services would be managed there. Early, clear decision-making on the role of these assets in the future would allow for more effective planning, clearer communications and faster turnarounds for some elective procedures.

Question 3: How well did we adapt services to respond to challenges of Covid-19 and opportunities to change?

Finding A: Flexibility across services to drive and embed change

As referenced in the above section on what went well, there have been considerable steps towards a move away from patients receiving treatment in acute sites when there are appropriate options either in the community or elsewhere. The challenge for the recovery and remobilisation phases will now be how to ensure affected services embed the changes made during the pandemic response. Clinical teams will need support to prevent them from reverting to old ways of working, and patients and the wider public will need continued support to inform them about the most appropriate contact points within the health and care system for their needs. While hospital productivity remains impacted by Covid-19 and below previous performance for all elective treatment, primary and community services will need to continue to support backlog management and waiting lists by continuing to innovate and work flexibly within their systems to triage patients appropriately and reduce clinical risk.

Finding B: Shielding Programme

The Scottish Government's shielding programme was introduced in March 2020 and advised shielding of those at highest risk of developing serious illness if they contracted the virus. Those who were shielding were given support, including free grocery boxes, home delivery of medication, and priority access to supermarket home delivery slots. By listening to those who were shielding, it became clear that isolation was having a major impact on the mental health of many people, and a more person-centred approach was needed. As a result, in June 2020, changes to shielding advice were issued moving toward more detailed clinical advice about personal risk and to help in understanding the changing level of infection in the community. This will remain crucial for future waves and any future incidents, ensuring that person-centred approaches and public engagement remain crucial to how interventions are designed.

Finding C: Sustainability of the workforce

Recovery of the health and Social Care system must consider the effect and impact of the pandemic on the physical and mental health of those involved at all levels of the pandemic response. All members of the health and care workforce have faced their own issues from concerns about their own health, caring for families, strain on relationships and looking after children during such a heavily restricted time, as well as other reasons. The National Wellbeing Hub was created with an approach which is based on psychological first aid, promoting resilience following trauma exposure. Since its launch in May 2020, it has received over 63,000 visits. The Wellbeing helpline launched in July 2020 providing 24/7 service to those who require confidential support. In addition to these national staff wellbeing programmes there have been multiple local initiatives which have been well received, including delivery of 'Comfort Boxes' to NHS wards, departments and care homes across the Grampian region, and the distribution of "You are Appreciated" postcards in Tayside. The supporting of staff wellbeing is critical, and the welfare of the workforce is a fundamental interdependency that cuts across every aspect of re-mobilisation planning. The evidence base and learning from previous pandemics demonstrates clearly the need to provide on-going support to promote both physical and psychological wellbeing during this next re-mobilisation phase, and it is clear we should be looking embed systems of support for the longer term.

Key Takeaways:

1. **Workforce planning:** Pre-dating the Covid-19 pandemic, Scotland (as well as other healthcare systems internationally) has faced particular challenges around workforce vacancies in the Acute sector, for example nursing and midwifery have both experienced an increase in vacant posts and the rise of using supplementary staff to meet demand (as noted by NHS Scotland workforce reporting). This example evidences the pressures faced by Scotland's NHS in maintaining a sustainable workforce. Recognising the considerable work done on national workforce planning to date, the development of policies and working conditions that support staff to stay in the profession will be crucial to support the recovery and remobilisation of health and care services across Scotland.
2. **Workforce wellbeing:** The pandemic has further highlighted the number of vacancies needing to be filled within NHS Scotland and that the risk of burnout amongst healthcare professionals is much higher than before. Supporting our healthcare professions during this time must be a priority for all and should go beyond the scope of showcasing appreciation through a number of initiatives, there is a need for long-term genuine commitment to the welfare of physical and mental wellbeing of healthcare professionals.
3. **Agile ways of working:** The Covid-19 crisis has required the NHS to operate differently and we have seen throughout this chapter, examples in which rapid reconfiguration of clinical practice has successfully taken place over a short period of time which would ordinarily have taken months to years. We must recognise the achievements of the Acute response to Covid-19 to date and reset the ambition for what the future health system should look like.
4. **Governance for a future pandemic response:** It is clear that change has happened as a result of the pandemic, in every part of the health and Social Care system. This has been built bottom up by leaders who have worked successfully together to tackle the challenges presented by the pandemic. This united approach has been a success in large due to the removal of various bureaucratic layers that have previously hindered the progress of improving patient care. Virtual meetings and leaner governance have sharpened and accelerated decision making which has in turn altered NHS working culture. It is vital that learning from this work is taken forward and health leaders are listened to, to create a lean, agile and patient focused framework for the NHS.
5. **Achieving greater integration:** The pandemic has demonstrated the crucial interdependencies between different parts of the health and Social Care system, and with other parts of society. An effective approach to mobilisation needs to recognise the important connections between services and systems and helps them work together. This will be clearly shown during the recovery of elective procedures over the coming months, and the priority work being done to manage the backlog created during Covid-19 will require strong collaborative working, particularly with Primary and Social Care to appropriatley mitigate any clinical risk.
6. **Digital integration:** The challenge now is to return services as much as possible to being fully open and accessible whilst not losing some of the gains and improvements that have been made during the pandemic. Consideration should be given for a national approach to the improvement of infrastructure and an increased emphasis on wifi availability to enable the use of digital. A good example of this includes significant equipment rollout that has taken place during the initial phase of the pandemic enabling Community Pharmacies to have wifi in place. Boards should be asked to undertake a gap analysis on this as there still remains, particularly in GP practices regarding shortages of kit.

3. Social Care (Care Homes)

Introduction

This chapter specifically focuses on the social care response in the first six months of the Covid-19 pandemic. Key representatives from the Social Care Directorate were engaged in order to frame this focus of this chapter and to provide insights into its content. It is largely illustrative rather than comprehensive but nevertheless provides some helfpul insights to inform future responses. It was agreed that the scope of this chapter was on the synthesis of previous sources with a focus on the care home sector. This review therefore sits within a wider context of lessons to be learned from across the whole Social Care system which should inform future phases of work.

What is the challenge?

Covid-19 continues to present an unprecedented challenge to Social Care and has focussed attention in the media and more widely on the sector, its staff and service users. It has been well reported that in the initial stages of the pandemic, the care home sector experienced a significant increase in excess deaths of residents, coupled with an already stretched workforce which has undoubtedly put a strain on the sector. The pandemic has given the opportunity to rethink how Social Care is delivered, its place in the wider health system and learn lessons from how we responded to the first wave of the pandemic. This is being done alongside the Independent Review of Adult Social Care (Feeley report[2]).

What has worked well in Scottish Organisations so far

Finding A: Use of data for oversight (specifically through the Safety Huddle Tool)

1. Stakeholders described the development and implementation of the '**safety huddle TURAS care management tool**' within the care home sector as a valuable development during the pandemic. The key elements of this were that it enabled a consistent approach to data collection, report staffing decisions and permitted early escalation and warning of issues to allow for timely support and interventions. Throughout the pandemic, providers demonstrated a high level of initial and continuing commitment to the adoption of the tool, and it has been used by multiple groups. At local level this has included local oversight teams and care homes, while at national level the Care Inspectorate and Scottish Government for the GOLD Social Care Group. The tool has generated daily intelligence on the current situation in all care homes across Scotland and has future potential as an important building block for quality improvement infrastructure. This tool has meant that for the first time ever, a standard data set was available in near time from almost all care homes in Scotland. Looking into how this can be used in the future, the tool offers a more partnership-based approach to supporting improvement in care homes.
2. Stakeholders also noted that data has been used to great effect to be able to validate discharges to care homes using hospital and other data sets. This continues to form part of new ways of working, with the Care Inspectorate for example creating a service data

[2] https://www.gov.scot/publications/independent-review-adult-social-care-scotland/

Finding A: Use of data for oversight (specifically through the Safety Huddle Tool)

dashboard to be shared with Scottish Government to provide rapid notifications of incidents and therefore a clear picture of the challenges being faced by services.

Finding B: The effective use of digital enablers to improve care

1. Where care and support was reduced or suspended during the pandemic, partnerships were required to put systems in place to support clients, families, and carers to ensure they were safe and well. This was done in several ways using technologies such as Near Me, Microsoft Teams and other Telecare approaches (e.g. access to GPS technology for people with dementia). Stakeholders identified that the pandemic has enabled this **swift introduction of new technology and adoption of digital working**, including expansion of telephone triage and Near Me video consultations for patients. Key findings from video consultations were that they were effective in maintaining continuity of care and allowed staff to build a different kind of relationship with service users.

   It is, however, important to note that some concerns have been raised around the ability of all service users to access technology which needs to be investigated and addressed with many areas are working to retain and further embed the use of Near Me. Colleagues reflected that during the pandemic, ways of working changed, and old systems were switched off which created capacity and robustness to the infrastructure for novel innovative ideas.

2. Stakeholders reflected that prior to the pandemic, although the infrastructure between care homes and primary care was in place, this was not well utilised which was a particular issue early on due to some care homes having poor digital access. Although beyond the scope of the first six months of response, we note here that an **action plan for digital approaches in care homes** was published in December 2020 which responded to the current and emerging needs of care home providers and their residents to realise the benefits of digital technologies, with implementation of this occurring in the preceding months.

3. Finally, stakeholders noted that local teams also benefited from the use of technology to carry out assessments and holding virtual team meetings including ward rounds for care homes. Teams felt this worked better than usual meetings and assessments due to the increased flexibility for those taking part, making participation independent of geographical location. In addition, **technology also proved vital in supporting staff wellbeing**, particularly with many care staff working from home due to shielding. Wellbeing and a strong sense of community has been highlighted in all three follow up chapters and stakeholders commented that despite being virtual, this ability to provide peer support was still effective through technology.

Finding C: Collaborative working and relationship building

1. During the pandemic, the interdependencies between hospital and community health services were shown to be crucial (as well as other, wider system relationships). It was reflected by stakeholders that there has been **a shift in attitude to adopt 'whole system thinking'** across the system, with examples cited including system-wide supplies of PPE and joint working between partnership colleagues and external providers.

2. At the local level, every Health Board and its Health and Social Care Partnership in each Local Authority were requested by Scottish Government in May 2020 to put in place a **daily multi-disciplinary team** comprising of NHS Director of Public Health, Executive Nurse Lead, Medical Director, Chief Social Work Officer and Health and Social Care Partnership Chief Officer. The MDT sought to provide integrated oversight for, and support to, care homes through proactive targeted interventions. Colleagues reflected on the success of this due to its cross-functional make-up and felt both the overall oversight provided and the meeting became a key forum during the initial stages of the pandemic and continues to be of use.

Finding C: Collaborative working and relationship building

3. At the national level, the Care Homes 'Rapid Action Group' was quickly established to provide a multi-stakeholder focal point for the work being undertaken to support the effective delivery of care home provision during the coronavirus pandemic and future scenarios. Its remit has now widened to social care under the Pandemic Response in Adult Social Care Group and membership includes Scottish Care, the Care Inspectorate, Public Health Scotland, Directors of Public Health, and the Scottish Social Services Council, among others.
4. Another example was the **creation of the CMO and CNO Clinical and Professional Advisory Group (CPAG)** in April 2020 . It has representation from care home providers, academics, local oversight teams, clinicians, Directions of Public health, the Care Inspectorate and others and has provided clinical and professional advice and guidance on the response to COVID-19 in the social care sector. It consistses of various subgroups including e.g. short life working group on testing, safety huddle group providing national and clinical guidance, visiting, testing and Infection Prevention and Control guidance. The CPAG. Recent work streams have included assisting with the IPC manual, publishing the Open with Care visiting guidance and engagement with relatives of care home residents.
5. Finally, documents reviewed reflected that the development of **'profession to profession' care pathways** was key to the response. Improving relationships and effective communication between primary, secondary, community and Social Care was key to successful interface working. This was also supported by the **temporary move away from target and number driven messaging** i.e. waiting times and attendances at A&E while the key focus of teams was Covid 19 response.

Finding D: Innovative initiatives to temporarily increase workforce capacity

1. There were a number of workforce initiatives both regionally and at a national level put into place to ease the pressure on the existing workforce. This inluded at the outset of the pandemic the Scottish Government commissioning NHS National Education for Scotland and Scottish Social Services Council to develop a new **Health and Social Care Covid-19 Accelerated Recruitment Hub** (the Recruitment Hub) to enable those with relevant skills and experience to come forward and support health and social care services. Its purpose was to enable social care employers prepare for and manage changes to their staffing levels during the crisis. On reflection the number of people employed through the Recruitment Portal is lower than originally expected due to a range of reasons including employers being able to source the right staff, effective local intiatives to provide support and a reduction in demand for care at home services. Other measures included , the introduction of seven day working which were utilised was reported to work well, and the redeployment of staff from paused services. Some partnerships undertook detailed modelling to predict sickness absence and modelled workforce requirements accordingly. Stakeholders did reflect on the success of these initiatives in the same way as identified in the Acute sector, where large numbers of staff were identified for re-registration but a reported low level of actual placements.
2. When the Covid-19 pandemic took hold in Scotland in early March 2020, the **Care Inspectorate significantly increased levels of contact with care homes across Scotland**. They put an early warning system of enhanced notifications in place, requiring services to tell the Care Inspectorate about both suspected and confirmed cases of COVID-19, and staffing levels affected by COVID-19. The Care Inspectorate operated these oversight arrangements seven days a week to carry out scrutiny checks and enhanced their communication to providers with daily Provider Updates, a COVID-19 area on website, and information on social media. Working closely with NHS public health and Healthcare Improvement Scotland, the Care Inspectorate commenced onsite inspections for those services where risk was indicated as high.

Finding E: A re-prioritisation of care provision away from Acute providers towards the community

1. In an existing lessons identified report reviewed for the purpose of this work, partnerships reported decision making and **discharge arrangements had been streamlined** at the start of the pandemic. There was an accepted need to create hospital capacity, therefore discharging people who had no clinical need to be in hospital was deemed an urgent necessity. Coupled with a fear of remaining in hospital for individuals and their families, many of the historic behavioural barriers were removed and key elements of this should be retained for future ways of working. Prolonged delays over choice were dealt with speedily with a desire to be moved out of hospital quickly and family resistance dissipated. These were factors that returned as deaths in care homes became more widespread. In general, there did not appear to be any barriers to fully adopting a 'Home First approach' with long standing behaviours and attitudes to risk being the main obstacles.
2. There have been multiple contributing factors cited for the decrease in A&E attendance and hospital admissions throughout the pandemic including: increases in the use of triage and assessment; increased signposting to other services; primary care teams seeking alternatives to hospital referrals; and paramedics providing more treatment in situ to reduce admissions. **Some teams noted more direct access to hospital consultants to enable decisions** about whether to admit a patient. It is important to note that there is further thinking and work to be done about the sustainability of maintaining aspects of these as services move into the "new normal".

Finding F: Positive culture shift towards whole system approach

1. Prior to the pandemic, there was a perception that care homes were viewed on the 'periphery' of the provision of care, and it was felt that in some places there was therefore a lack of equality for residents in care homes to be able to access the right care and support. This view has now shifted to **care homes needing to be viewed as part of the wider health and social care system including in primary care team.** Stakeholders noted there had been a significant shift at both operational and strategic level towards whole system thinking, which has been enabled by information sharing, remote working, teamwork and locality approaches. There was reflection in documents reviewed about how well embedded this view of working was and whether this would be sustainable in the future with barriers including a continued national focus on Acute services and hospital as the default.
2. It was noted that there is a significant piece of work underway in Scotland which is reviewing the clinical and healthcare model of care for provision of **whole-needs support for residents** in care homes. Stakeholders commented that in some places there was previously a perception of an 'out of sight, out of mind' approach with respect to care homes. The pandemic highlighted some potential weaknesses within the system, particularly with vulnerable service users living in environments that were seemingly unprepared for the pandemic.
3. Early in the pandemic, the minister for mental health chaired a group around **mental wellbeing for Health and Social Care staff**. From the outset an inclusive approach was taken recognising the significant challenges to wellbeing for staff across both health and social care but particularly in care homes. This resulted in the development of a national integrated digital wellbeing hub for health and social care staff, carers, volunteers and their families to access relevant support when they need it. The hub is supported by a range of organisations and provides a range of self-care and wellbeing resources designed to aid resilience as the whole workforce responds to the impact of Covid-19. Although it was felt that there was a multitude of resources available to colleagues regarding wellbeing, it is not clear what the take up was and continues to be for these.

Opportunities identified for further resilience:

Finding A: Limited pre-existing governance structures across Social Care

1. It has been highlighted from documents reviewed, one criticism of the internal Scottish Government response to the pandemic was a lack of subject matter expertise on Social Care (in particular for care homes) among key decision makers within Scottish Government. This led to a perceived **overreliance on key members of staff with this knowledge** who had limited capacity to support all aspects of the response. Documents reviewed suggested concern that this reliance on key individuals will continue to present an issue if there are further waves or future incidents.
2. Some partnerships have alluded to difficulties presented by new oversight arrangements with a feeling that there was a **lack of clarity about levels of accountability** within these structures. This challenge was highlighted when there were attempts to use parts of the system in an assurance role without having previously had this experience over care homes.
3. Documents reviewed suggested a **devolved management model** in relation to care homes meaning that when the Covid-19 pandemic did occur, the information, about what was happening at care homes, and held centrally within Scottish Government was limited. This is a consequence of the arrangements around the provision of Social Care in Scotland, with multiple providers working independently within each territorial Board. Providers had no previous requirement or incentive to provide data in consistent ways or work in an integrated way, and this hindered the ability of Scottish Government to make national-level decisions throughout the early pandemic response. This also raises questions about the level at which these decisions should have been made, with further clarity being helpful over the different roles of local and Scottish Government.

Finding B: Challenges with Communication

1. A lack of effectiveness of communication in general was highlighted as a key point across many of the documents reviewed, including the Coronavirus (COVID-19): care home outbreaks - root cause analysis. Stakeholders highlighted a **perceived lack of information available to their service users** about how to access the system but also around withdrawals or changes made to existing packages of care as being key examples of areas where communication should be reviewed for future incidents.
2. There was recognition that guidance for care homes was iterative as the pandemic progressed and knowledge about Covid-19 developed. However, stakeholders highlighted a **fine balance between updating latest guidance and being able to implement and understand repeated sets of new guidance**. Stakeholders reported this caused a substantial amount of stress and frustration, and in some areas strained relationships with care home providers. A suggested change here was the inclusion of a summary of 'key changes' or similar for any iterations of guidance, as providers reported not being able to clearly distinguish changes in guidance between iterations.
3. In terms of the national guidance, several partnerships made comments around a theme of "one size doesn't fit all" – meaning **national policies were not always tailored appropriately to local requirements**. This contrasts to elements of the Public Health response, where the importance of both local knowledge and national oversight was a key facet of the response. This is exacerbated by the devolved management model as referenced above, but any future guidance with relationship care homes ought to consider local circumstances alongside national consistency where possible.
4. Partnerships within documents reviewed commented on **the timing of announcements as being unhelpful,** for example guidance being released on a Friday with changes to be made

Finding B: Challenges with Communication

by the following Monday. We note this finding is also consistent with other chapters in this report and is not exclusively applicable to the Social Care response.

Finding C: Lack of consistent data

1. It was noted from previous work that the initial data which was available to the central Scottish Government team from the care homes and Local Authorities **was limited and sometimes lacking in quality and consistency**. This is reflected by the devolved management structure overseeing providers in Scotland. Considerable work has been done by the Scottish Government and other national agencies to create infrastructure for robust data collection and drive standardisation, which provides a platform for enahanced further planning and development into the future. The developments and large amount of work required reflects the relatively weaker starting position from which the care home sector found itself. Interviewees referenced that while they felt data in general had helped the response, particularly in the earlier phase of the pandemic it was often hard to locate when needed.
2. Documents reviewed stated the importance of information shared by care home providers, but also the need for processes to be improved to keep the demands on them to a sustainable level, coupled with the fact that **care homes are not always well linked in digitally in terms of email, and IT skills**. This reflects a potential risk to continued reliance on digital tools and ways of working wihtout accompanying training and on-going technical support for those wokring on the frontline.
3. There has been on-going improvement work between Public Health Scotland, NHS Boards and suppliers to ensure more **standardised data around admission to care home from hospital disc**harges. In addition, it has been highlighted that priority should be given to the development of a national dataset recording care home residents on an ongoing basis, to allow for a better understanding of the capacity and use of the sector.

Finding D: Negative perception about Social Care

1. Throughout our review, documentation provided highlighted that **the Social Care workforce felt undervalued and underrecognized** prior to the pandemic, and that there were reports of similar feelings during the early response. It is thought that the inclusion of Social Care staff, alongside their health colleagues, in public campaigns has helped but there is a deeper underlying sense that Social Care workers have not had parity of esteem with their NHS counterparts as noted in the Independent Review of Adult Social Care. It will also be necessary, in going forward, to consider some basic terms and conditions on issues such as sick pay, time-off, and travel time for social work colleagues and to renew focus on the importance and value of Social Care.
2. Numerous participants from previous interviews mentioned the Lord Advocate's decision to enable **Police Scotland investigations into deaths in care homes**. While acknowledging the need to assess what went wrong, participants expressed that this approach was substantially increasing the very high levels of anxiety being experienced by professional, skilled staff who support and care for the most frail and vulnerable people in our society and there is a perceived and felt search for blame.

Finding E: PPE distribution challenges

1. Many areas of Social Care have reported issues with accessing PPE at the start of the pandemic, with concerns over the quality and the ability of independent providers to access it. All areas set up local PPE hubs to help distribute PPE across partnership services, with some

Finding E: PPE distribution challenges

areas also bulk buying and distributing to all sectors. Some partnerships felt that the guidance at this stage was influenced by availability, and in some areas, there **was real anxiety felt amongst staff and service users**. After overcoming the initial issues several partnerships praised NSS for the supply process that was established via community-based hubs and triage support line and felt that it had worked well. It was reflected that in the future, the development of a national or regional PPE purchasing consortium would help address issues of quality and help share PPE fairly across whole sector.

Finding F: Workforce Challenges

1. There have been many workforce challenges highlighted throughout the documents reviewed. A few examples include the **lack of initial prioritisation of Social Care workforce** in early stages regarding PPE including possible diversion of pre-pandemic resources towards NHS and other public authority provided services, trauma experienced by workforce during pandemic which is thought will have long lasting effects and potential inequalities in access to testing between staff.
2. **Staff absences** was cited as a significant challenge for many areas of Social Care. In some areas, care at home staff have been described as an ageing workforce, which resulted in many staff shielding. In general, colleagues reflected that once regular testing of staff commenced areas saw absences reduce significantly as people had the confidence to return to work knowing they had tested negative.
3. It was reflected that there is currently **no national oversight of workforce planning for Social Care in Scotland** with around 1,200 social care employers in Local Authorities and the third and independent sectors, the complexity of the sector made it sometimes difficult to ensure appropriately skilled staff were trained, supported, employed and available in the right place at the right time. However, in some local areas through partnership working between Boards, IJBs, Local Authorities and social care providers it was possible to deploy appropriate staff quickly and at scale. Longer-term, problems that have surfaced, given the complexity of the social care sector there are difficulties in planning ahead for training, recruitment and retention, and failure to work with partners in health and housing in particular to model innovative new approaches that depend on the availability of a suitably trained workforce who understand each other's contributions.

Finding G: Infection prevention and control challenges within care homes

1. Several documents, in particular the Root Cause Analysis report, reflected on the support provided by Public Health consultants and staff during the crisis which had proved extremely helpful in terms of addressing staff and union concerns around PPE and providing advice and guidance on appropriate infection control procedures. However, it has been reflected by colleagues that **different guidelines and support for health and social work around infection control and safeguarding led to some confusion** within the sector initially with the continually changing guidelines around the use of PPE were also noted as challenging.
2. It was reflected by colleagues that responsiveness at the point at which issues were raised and became a matter of concern was good however there may have been **issues that could have been anticipated earlier**. There is a need for both health and Social Care to promote more proactive and anticipatory interventions in the future.
3. It has been reflected by colleagues that it is likely that there was a presence of focused interventions by way of training and support, around specific care homes which had experienced outbreaks. It is possible that these were prioritised over care homes that hadn't experienced an outbreak meaning that these care homes were underprepared when

Finding G: Infection prevention and control challenges within care homes

outbreaks did occur. While documents reviewed recognized the importance of this prioritisation, the inability to share good practice through a lack of existing integrated working or information sharing was felt to have led to inconsistencies across providers.

4. Managing transmission risk in relation to isolation of those residents with dementia was also reported by colleagues as **constrained by the built environment** within the care home and required enhanced monitoring. Some of the IPC advice was challenging in the context of balancing harms, as keeping an individual's environment familiar to them, in terms of personal belongings, was an important aspect of care in this context. Partnership organisations expressed concern that Infection, Prevention and Control (IPC) was **making care homes into 'mini hospitals'** and that there was a desire to return to recognising care homes are people's homes. This concern also featured in documented discussions with the care home managers from the four homes currently experiencing large outbreaks in this second wave, and additionally it was raised by national organisations and by the family representatives. The importance of risk-based and proportionate IPC, inclusive of its application to visiting, is critical to the sector.
5. Symptom recognition in older people was highlighted as key to the control of Covid-19. In documents that have been reviewed, there was evidence that primary care and emergency services colleagues had brought recognition of wider Covid-19 symptoms to the attention of care home staff during a resident review. In May 2020, Scottish Government's Health and Social Care Directorates issued guidance detailing the wider spectrum of symptoms seen in older people, to be considered for all care homes.

Finding H: Visiting of external services and resident families to care homes

6. Colleagues reflected on the provision of healthcare services to care homes during the pandemic and that this was described as inconsistent before the pandemic. Providers reported a range of visitation experiences, from minimal ''ignored' GPs input to other care homes where Primary care services including GPs are actively providing clinical advice and support. There was a reflection about the **need for more consistent clinical input required for care homes in genera**l. Stakeholders felt that, that there is a process of remobilisation of H&SC services across the sector, and guidance was issued around return of visiting professionals for care homes.
7. Colleagues reflected on delays in recognising **the impact of closing care homes to visitors** in March 2020 and highlighted that this evolved as a consequence of experience and through listening to the voice of relatives, there was a question around if care homes could have been opened to visitors at an earlier than June 2021 for the benefit of residents. Visiting issues began to materialise particularly in April and May 2020 when colleagues were working towards was the contribution towards the route map out of lockdown. Colleagues reflected that it is important to note now with hindsight reflecting on the duration of the pandemic, the mitigations in place and the impact isolation has had on residents and their families.

Key Takeaways:

Greater collaboration and integration: Stakeholders referenced care homes in particular as being perceived as being neglected within systems prior to the pandemic. Initiatives such as the daily safety huddle and the MDT meetings have highlighted the crucial role of Social Care during incident response and new ways of working. The role for Social Care going forward should be reviewed in the context of recovery, with stakeholders noting the perceptions of care homes as being 'mini-hospitals' needing to be avoided in particular.

Key Takeaways:

Workforce planning: Stakeholders reported the devolved management structure within Social Care (particuarly for care homes) placed a significant strain on the ability for a national workforce planning approach. Reactive measures were required at local levels with inconsitent data upon which to base decisions more widely. This could be mitigated by a more systematic, regional or national approach to workforce planning, with a focus on new, integrated ways of working, building a diverse and skilled pipeline of future staff, and embracing system working.

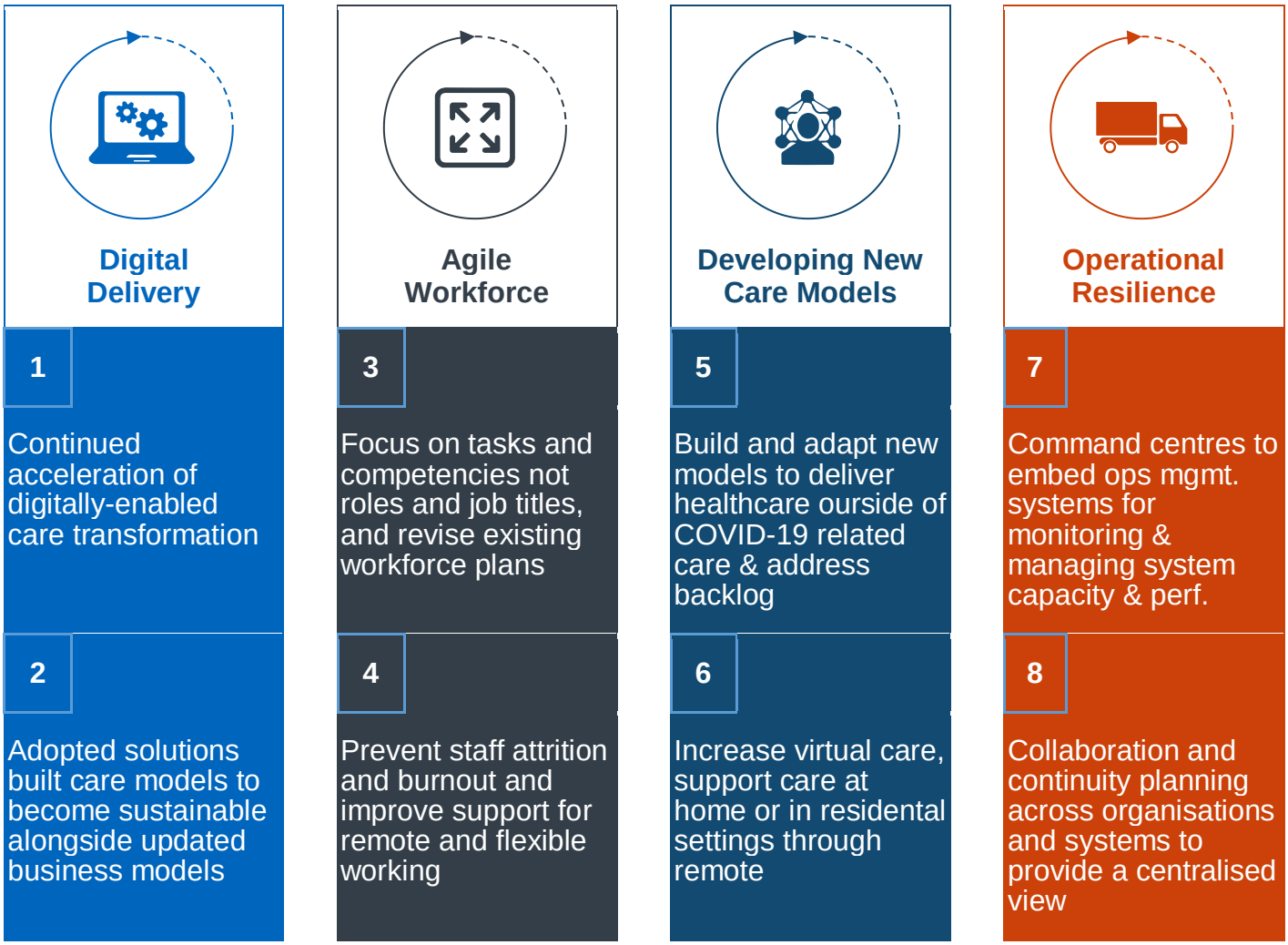
Agile ways of working: Enabled by the significant advancements made in digital tools and technology, there is now an opportunity for those working both within and with care homes to embed new ways of working. Such progress in this area can, in part, help address highlighted concerns by some stakeholders around visitation (of other services to provide greater, more consistent clinical input and families of service users), and integrated working with wider system partners.

Governance for a future pandemic response: A key finding highlighted by all stakeholders and in documents provided pointed to the challenges faced by those working in the response by the devolved management model for care homes in Scotland, in so far as the large number of different providers made coordination and standardisation challenging where desired. As with other areas of the pandemic response, significant work has been done to address these limitations to date, particularly around the lack of consistent data. Further work by Scottish Government and within territorial Boards to drive consistency and encourage greater collaboration would support the pace of any future responses to incidents.

6. Conclusion and Next Steps

This report has found a series of specific, local learnings through reviews of existing documentation and follow-up interviews with identified stakeholders. There have been a number of instances of identified good practice from within individual organisations identified within Sections 4 and 5 of this report, as well as insights and learnings for areas of increased resilience from different groups which should inform the shape of the the Government's on-going response. Based on both Scottish and global perspectives, clear, common themes for successful and sustainable recovery for health systems and providers in Scotland are emerging. To return organisations to sustainable operations with high levels of preparedness for future potential waves of Covid-19, international insights suggest that there are eight key actions for health and care leaders to focus their resources on as pandemic response continues and remobilisation plans are refined.

Illustration 05 – Eight Key Actions to Consider Going Forward



As part of these eight identified actions that remain important for all health and care organisations both within Scotland and internationally, this report outlines three high level findings that cut across all elements of NHS Boards' and Social Care organisations' responses to the on-going pandemic, as well as remobilisation plans. These three areas are:

1. **A recognition of the importance of multiple stakeholders involved in any decision-making**. This has been identified from the perspective of patient engagement and communication, working with primary care, community and Social Care, as well as governance

and leadership. Diverse viewpoints and insights into key decisions mitigates the risk of unintended consequences, as well as increasing the pace at which integrated responses to system-wide problems can be initiated;

2. **The centrality of digital and data to the provision of health and Social Care now and in the future**. This report considers two specific elements of the digital response to the pandemic: the use of digital tools in existing and new clinical pathways to treat patients and service users, and the wider consideration of access to these digital tools with specific community groups and staff members. A recurring finding across interviews and documents however is the increasing reliance on data across health and Social Care, testing, to workforce planning. While the required infrastructure to support this has been developed at pace, and considerable early preparation work has been undertaken by the digital team, there remains a significant demand for data that will continue to pose challenges for staff capacity, available skills and effective working across organisations over the coming months; and
3. **The changing shape of existing roles and responsibilities, and how teams interact within and across organisations.** With the pace required as part of the pandemic response, regular references were made to staff working outside existing roles across testing, modelling, digital, and general governance teams. Staff have had to act up or down in roles, and sometimes across organisations to ensure tasks were completed on time and decisions made. Named individuals previously held named responsibilities, a significant majority of which have evolved significantly over the first wave response. As part of on-going iterations of this exercise, a continued assessment of how roles and required skillsets are changing must be considered. The risk of staff become settled in new roles that do not align with previous organisational requirements presents a risk for burnout, sustainability and effective working across health and Social Care going forward.

The scope of work to date has centred on a review of lessons identified up to a specific point in time, with findings limited to the documents shared and the key stakeholders identified over a brief period of engagement. Through our conversations and reviews of documentation, stakeholders have referenced the existence of additional documents that will highlight key learnings, and key individuals who have been involved in the first response phase with additional insights to share. It will be important for the Scottish Government and NHS Scotland to continue taking stock of lessons identified, and for there to be an appropriate mechanism through which lessons can be identified and shared across the health and Social Care system. This document will represent a cross-section of some individuals' perspectives on the response to date, and while all efforts have been made to ensure this is representative, Government should ensure that future iterations of this work continue to identify findings from across the broader health and Social Care system from both staff and patient/service user perspectives.

Next Steps for future Lessons identified Activities:

In the creation of this report, we have identified a series of suggestions to consider as part of any future similar pieces of work as Scottish Government and/or NHS Scotland determine how best to ensure lessons continue to be captured throughout response and remobilisation. These are:

- There is a variable level of output from the documents reviewed during this exercise. We have not identified a consistent approach to identifying the lessons identified from the response within or across organisations, and future iterations of this exercise will be enabled by a more standardised approach to ensure key findings are easily identifiable and shareable. Key elements of this approach would include standardisation of themes reviewed, questions asked, and the frequency and format of outputs produced; and
- Many organisations have engaged with this process by sharing documents with us, and the authors of this report thank these organisations for their contribution to the report. We have found that individual and group consultations have however provided a much more rich source of findings, both anecdotally and evidence-based. If this exercise were to be repeated within Scottish Government or organisations, it will be important to capture first-hand experiences from as wide ranging a group of staff and other stakeholders as possible. Continued focus

groups or standardised surveys shared with broad groups will offer deeper insights for on-going remobilisation and response plans and would complement existing work done on formal lessons identified reviews.

It is important to recognise here that NHS Boards have responsibilities under the Civil Contingencies Act to learn from incidents and that Boards should continue to carry out local exercises to identify lessons identified from the ongoing response to the pandemic. Scottish Government will be able to play a key role in both coordinating this process across Boards, but also ensuring any areas of good practice or areas for improvement will be appropriately shared across both other Boards and into the wider Social Care sector. It will be important to ensure there is no duplication of effort across Boards and Scottish Government here; clearly defined roles and responsibilities for the implementation of lessons identified exercises (for Boards), alongside the central oversight and coordination of findings (for Scottish Government) will mitigate this risk.

Appendix: Case Studies

Case Study		
1. Ontario Health – Lab Capacity and Testing in Candada	Ontario Health	
2. NHS Foundation Trust – Green/Blue Sites in England		
3. Primary Care Referral Centre – England		
4. Welsh Health Board – Review of Integrated Care in Wales		
5. Partnering with Private Hospitals in Australia		
6. Patient Activation and Engagement with the public in Israel		
7a. NHS Orkney in Scotland	NHS SCOTLAND	
7b. Supporting the Nightingale in England Supply Chain and Global Learnings from Australia		
8. Use of TeleHealth to Address Covid-19 Needs in the USA		
9. Sustaining Virtual Care in Canada		
10. In-House Communications during Covid-19 in England		T’
11. NHS Foundation Trust – Working to a shared vision in England		
12. NHS Nightingale – Workforce in England		
13. ‘Team Time’ Initiatives in Ireland and England		
14. Welsh Health Board – Findings on Governance in Wales		
15. NHSE Elective Service Restoration in England		

1. Case Study	Ontario Health – Lab Capacity and Testing in Canada		

Challenge

In the midst of the pandemic response, Covid-19 testing in Ontario was lagging behind all other Canadian provinces and territories through a siloed approach involving a handful of disparate providers, creating a critical gap in the province's response to Covid-19. In the context of a growing backlog of samples waiting to be tested, increasing turnaround times (typically 4-6 days) and consistent critical media coverage, from late-March 2020, external support was engaged to diagnose the current state and establish a rapid solution to testing.

This has included supporting Ontario Health in establishing an integrated Covid-19 Provincial Diagnostic Network to coordinate testing provincially and evolved to include all aspects of testing: testing strategy, future capacity requirements, process automation, lab operations, assessment of new capacity ideas and transition planning.

Approach taken

a. Rapid diagnostic assessment

- Conducted a rapid review of the current Covid-19 testing landscape and approaches to immediately expand testing capacity across the province in partnership with Public Health Ontario.

b. Establishing integrated provincial testing network operations

- An integrated provincial testing network was quickly established, later named the Covid-19 Provincial Diagnostic Network, powered by the Covid-19 Provincial Diagnostic Network Operations Centre. The Network Operations Centre (NOC), primarily supported the integrated daily coordination of resources, procurement and test routing for Covid-19 testing in the province through Operational Huddles of all network laboratories.

c. Evolving and sustaining the testing response

- As testing volumes increased, the operations of the laboratory network became more complex. The Provincial Diagnostic Network evolved to refine daily operations but also prepare the network for future waves of Covid-19. The refined approach incorporated two important updates beyond the laboratory network operations: lab capacity strategy and transition planning.

Benefits/Lessons identified

Key learnings from what the local team felt 'worked well' have been captured below. These were deemed to be the 'critical success factors' for an effective testing approach and therefore may provide some insight for local, Scottish responses going forward.

- Leveraging the collective laboratory capacity across the province enabled rapid scaling of testing capacity for the province from 3,000 tests per day capacity to over 40,000 tests per day capacity (more than 13x increase).
- Regular engagement and coordination with all laboratory providers in the network helped share validation approaches to avoid repetitive tasks for each lab, resolve specimen overflow to maximize capacity, gather daily performance metrics and ultimately provide transparency into provincial operations

1. Case Study	Ontario Health – Lab Capacity and Testing in Canada		

- Setting clear expectations regarding operational protocols through the Operating Manual and accountability agreements provided mutual understanding of requirements from each laboratory
- Diversification of testing platforms mitigated global supply chain issues to protect provincial testing capacity
- Separation of new ideas intake and assessment from daily operations allowed the laboratories to focus on scaling capacity without distraction from vendors
- Engaging testing experts helped to rapidly provide testing guidance recommendations to the Chief Medical Officer of Health to ensure any Ontarians requiring or wanting a Covid-19 test could get one.

2. Case Study	NHS Foundation Trust – Green/Blue Sites in England	

Challenge

As part of the first wave response to the pandemic, a pause on elective procedures provided hospitals with the capacity to treat the increased number of Covid-19 patients without putting non-Covid-19 patients at risk of contracting Covid-19, as well as making staff and facilities resources available. This has led to concerns around a backlog of elective procedures, with an increased challenge as hospitals move into the winter months of dealing with rising Covid-19 cases in addition to trying to maintain elective services.

Approach taken

Having considered options to implement green or blue zones within hospitals to manage the flow of both Covid-19 positive and negative patients, this multi-site hospital made the decision in early May 2020 to designate one of its sites as a 'green site' for cancer, elective surgery and non-surgical procedures. Detailed oversight from Gold command resulted in plans being created for new clinical leadership, governance arrangements, workforce, and Infection Prevention and Control (IPC), with new procedures established to support these areas. Key elements of the approach included:

- Approximately 600 Trust staff and 50-75 third party staff being identified for potential relocation across sites
- Defined protocols for movement, particularly for surgeons, to prevent movement between green and blue sites in the same day
- A programme of asymptomatic staff swabbing on the green site to identify potential carriers;
- A clinical model for five-day-a week operating theatre scaling up to seven days a week; six day working for endoscopy; and transfers of existing chemotherapy patients onto the green site was developed and implemented; and
- The recommissioning of four theatres, an increase in elective care beds, the removal of medical admissions to designated blue sites, and the conversion of A&E into an Urgent Treatment Centre (UTC).

Quality and Equality Impact Assessments were carried out, and the Trust engaged with Trade Unions weekly on proposed changes to the services.

Benefits/Lessons identified

At the time of reviewing current performance for the green site, a series of objectives had been set out and Trust performance against these was as follows:

- Planned surgery was able to resume at a level which maintained the existing waiting list prior to the pandemic. At the time of review, the Trust was able to deliver 90% of the required activity to meet this target, leading to a small increase in waiting lists;
- Cancer targets were significantly met, with referrals to the Trust returning to pre-Covid-19 levels. Patients previously receiving chemotherapy at this site continued to receive treatment, with almost all existing patients from other sites being able to receive treatment at the green site (almost 2,000 patients). Note where patients were not able to transfer this was due to them requiring multiple services (e.g. radiotherapy and LINAC); and

2. Case Study	NHS Foundation Trust – Green/Blue Sites in England	

- Urgent endoscopy lists being established meant the Trust had the largest recovery for diagnostic procedures of any hospital in the region.

The Trust also held a patient and staff survey to receive feedback on the approach. 95% of patients who responded felt the Infection Prevention Control procedures in place made them feel either 'fairly safe' or 'very safe', with some practical suggestions for improvement around available facilities for visitors. Staff fed back with additional practical suggestions, including ensuring that sufficient rehabilitation facilities are available within the green site.

3. Case Study	Primary Care Referral Centre – England	

Challenge

Patients were being found to be reluctant to attend primary care facilities due to concerns around Covid-19, while those with suspected symptoms were looking for appropriate sites for testing and diagnoses which presented risks to staff and other patients within primary care. This creates a significant risk for both increased transmission of Covid-19 between patients and staff, as well as an increasing back log of unmet need for primary care provision in the community as the public are unable to access care in the same ways they previously had.

Approach taken

As part of the commissioners' response to the shortfalls in primary care capacity, a dedicated Covid-19 Referral Centre (a 'red site' for suspected Covid-19 patients) was stood up at short notice to reduce the potential back log for cases and provide continuity of provision of primary care services to the region. This involved the creation of specific pathways for referral for Covid-19-presenting patients to be referred directly to the centre. Care was provided by a flexible staffing model that could be increased at short notice to manage anticipated demand. Input into the creation of the centre was sought from a multidisciplinary team covering workforce management, logistics, urgent and non-urgent patient transport, IT infrastructure and clinical pathway redesign.

Benefits/Lessons identified

- Construction of a fully functioning triage facility for Covid-19 patients to assess and test patients within three weeks;
- Capacity to treat up to 1,500 patients a day through a newly created pathway (where patients had been referred for Covid-19 symptoms);
- Fully socially distanced, 'drive-through' facility which supported the safety of staff and other patients, while releasing capacity for 'green sites' across the region to continue receiving non-Covid-19 presenting patients;
- Evidence of the effectiveness of 'locality hub' models whereby patients would be willing to travel to centralised hubs for care.
- Recognition of the importance of data infrastructure for temporary/field settings when increasing data sharing across partners and use of digital tools becomes more commonplace in the provision of care.

4. Case Study	Welsh Health Board – Review of Integrated Care in Wales	

Challenge

A Health Board in Wales has reflected on how the pandemic has highlighted that population health, care and support is 'everybody's business' and that the response goes beyond in-hospital provision of care. There is therefore a recognition that health and care services are only one part of a complex system that needs to work better together to improve health and wellbeing outcomes across the population.

Approach taken

Following the height of the first wave, the Board led a detailed review of activities undertaken during the response and constituted a new transformation group with representation from health (including primary care) and social and community care to capture and embed best practice from the first wave from June 2020. A key focus was placed on long-term care through a 'social model to health', and through this a number of key outputs were developed including:

- A regional 'Care Home Risk and Escalation Management Policy' approved and implemented by health, Social Care and care providers;
- Region-wide guidance on hospital discharge principles, intermediate care principles, and palliative care principles;
- An integrated end of life pathway, with partnership working between palliative care, nursing home providers, Primary and Secondary Care;
- A District Nursing Hub to coordinate new referrals for district services and to align community nurses where need is heightened; and
- The establishment of a PPE Cell with representation from local authorities, Social Care, domiciliary care, primary care, community services, mental health and learning disabilities and Acute care ensured an integrated approach through mutual aid.

Benefits/Lessons identified

Outcomes from the work done by the Board have been predominantly measured through clinician feedback rather than direct engagement with patients. Clinicians within the system reported benefits including:

- Virtual platforms to communicate with new colleagues to develop relationships and fast-track working together;
- Improved pace and scale of integrated commissioning across three local authorities and the health board; and
- Treatment of 20-30 patients a week through the district nursing hub with a reviewed caseload and workforce planning approach to inform future district nursing models.
- An appreciation of the work of care home staff - clinicians referenced an increased awareness of the shift patterns and conditions that care home staff worked in through closer working. This has led to an increased focus on the sector as part of the wider sustainability of the health system going forward.

5. Case Study	Partnering with Private Hospitals in Australia	

Challenge

Facing rising demand for public hospital space in the response to Covid-19, the Australian federal government sought additional capacity from private sector hospitals are part of a national deal.

Approach taken

At the end of March 2020, the Australian Government requested that all private hospitals provide assistance with the Covid-19 response by temporarily integrating with the public hospital network. The Australian Govenrment guaranteed the viability of private sector hospitals temporarily in return for these hospitals making both staff and beds available for the nationwide response. The scope of private hospital involvement in the response included:

- Hospital services for public and private patients;
- Urgent elective surgery;
- Utilisation of wards and theatres for additional ICU capacity; and
- Accommodation for quarantine and isolation cases (where necessary).

As part of this transfer of services, additional support was requested to ensure that all private hospital funding claims were appropriately audited and reviewed for appropriateness; a review of revenue mapping within organisations to ensure improved alignment of claims and transfer of payments; and there were appropriate, new governance structures in place to manage the increased administrative requirement of joint working.

Benefits/Lessons identified

There were two key outcomes to this approach. The first of these was the on-going solvency of the private hospital sector, which had been impacted by Australian Government mandates on reduced elective care. One private hospital group notes that none of its staff were stood down during the pandemic, and instead were made available for the national response.

The second of these was the support provided by the private sector to the public hospitals; the same private group found that it treated over 87,000 public patients between February and September 2020 with over 28,000 procedures performed. Staff from this hospital group also covered 1,500 shifts within aged care facilities to provide additional workforce where needed.

The fact that the national arrangement had been first mandated also allowed a local response, where state governments were able to flex local requirements with private hospital groups based on the national template.

6. Case Study	Patient Activation and Engagement with the public in Israel	

Challenge

Even before the additional impact of Covid-19, there is a recognition that healthcare systems globally are under increasing pressure. This is clearly seen within the NHS through a multi-morbid and growing population and a stretched NHS workforce to treat them. As part of this challenge, the largest healthcare provider in Israel has led the way on population health management by focusing on patient activation - the degree of patients' engagement with their own health. A specific focus on this work was on long-term care, with patients with comorbidities, and studies show that in the NHS while these patients spend 1% of their time with healthcare professionals, they account for approximately 70% of NHS spend.

Approach taken

This organisation has placed significant emphasis on social prescribing over the years leading up to the pandemic and how this leads to increased patient activation. These foundations and principles included:

- Ensuring it as simple as possible for patients to engage with healthcare (evidenced by an 81% increase in diabetic patients who attended eye tests when encouraged through an online account created for them compared to those without the online account);
- Ensuring treatment is personalised using algorithms. Patient preferences (informed by previous family medical histories or experiences) are used to target treatment towards their preferred aims and outcomes; and
- The use of apps to allow patients to engage with their own treatment. In Israel this provider launched an app which displayed current patient health information and identified risk factors. The app allowed patients to input lifestyle changes they hope to make, which links back into the health record for clinicians to approve appropriate prescriptions, tests or referrals remotely.

Benefits/Lessons identified

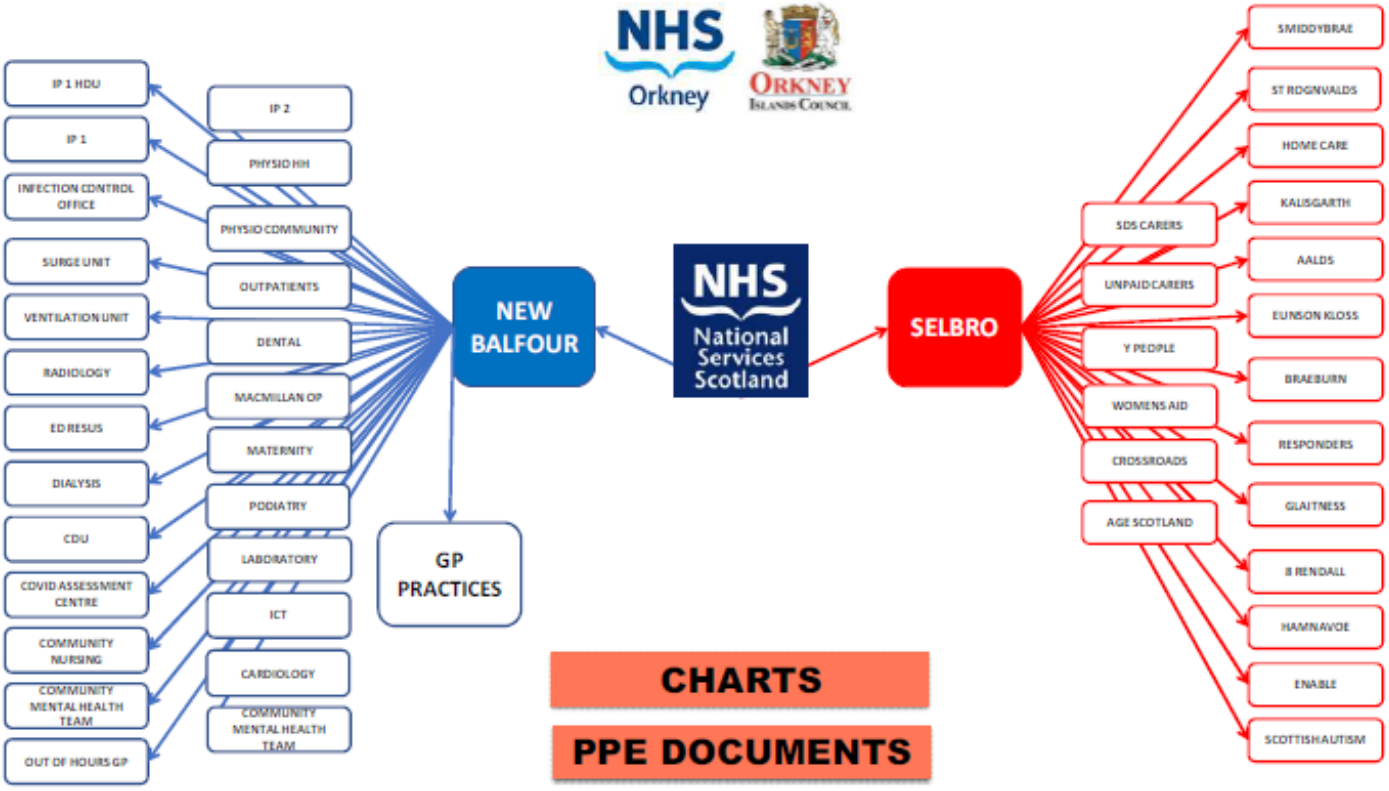
This organisation has reflected on the high emphasis for patient activation in Israel and how this may be applied across the UK to encourage self-management and determine how patients engagement with primary and secondary care in the current climate. These recommendations include:

- Investment in the assets but also skills to encourage patient-centered care. Patient activation starts with patient empowerment to manage their own care and to interact with health systems in a new way;
- Involvement of patients in the process of developing new tools. Co-production will help to support a shift away from organisation-led healthcare and will show patients how they can add value to their own healthcare; and
- Healthcare professionals should be supported to encourage patient activation through all communications. The principle that a patient should leave every encounter with the system more informed and more empowered to take control of their care moves focus away from a reliance on existing hospital or Social Care provision.

7a. Case Study	NHS Orkney in Scotland		

The supply chain for all PPE has been under significant strain locally, nationally and internationally however there is now an element of stability in the supply chain with more PPE being manufactured in the UK. This has allowed the supply chain to return to more of a 'business as usual' 'pull model' to support re-mobilisation. As the rurality of NHS Orkney naturally creates delays in the delivery of PPE and essential supplies compared to more urban regions, the Board has made the decision to create a buffer stock of PPE to support any local outbreak of Covid-19 until centralised stocks can be delivered by National Procurement. To further mitigate risk against any local shortages of PPE NHS Orkney is working collaboratively with Orkney Islands Council to mutually support any shortfalls from stockpiles to ensure services can continue to be delivered at point of need. This virtual hub arrangement is shown below and outlines the services that each partner will primarily be responsible for in terms of the supply of PPE.

Illustration 06: NHS Orkney Virtual PPE Hub Arrangements



Moving forward the re-mobilisation of services and maintenance of a parallel Covid-19 response means there will be significant demands on PPE for both business as usual and the maintenance of a local pandemic stockpile. As national pandemic stockpiles of FFP3 masks have been used and new and existing manufacturers come on stream NHS Orkney will continue with a rolling programme of face fit testing for staff to ensure that they are matched to a sustainable supply of FFP3 masks. This will ensure that services can be supported to remobilise safely and for the longer term. As part of the winter planning process further sustainable stocks of PPE will be required in order to deliver the broader flu vaccination programme. With the risk of concurrent events (including the potential impact of Brexit on the supply chain) NHS Orkney will continue to work collaboratively with local partners and national procurement to ensure that PPE and essential supplies are available locally and stockpiled to mitigate against the current pandemic and emerging concurrent risks.

7b. Case Study	Supporting the Nightingale in England and Supply Chain and Global Learnings in Australia		

Challenge

Historically, the supply chain needs of the NHS have been met locally, via a patchwork of local process and systems which have not been seen as core to the clinically-focused structure of the NHS. The challenge to these systems of the Covid response revealed that the structural issues in those supply chains threatens the NHS' ability to fulfil their mission. These causes include:

- Inconsistent data - the wide range of complex products and services are described in different ways and with different codes.
- The absence of common descriptors and Stock Keeping Units (SKUs) makes it difficult to share information on constrained items (including inventory levels) during a crisis and leverage procurement during 'business as usual';
- Inefficient processes - Processes are highly manual and do not link supply and demand - slowing down the crisis response and significantly reducing agility in the move to a recovery phase;
- Processes and systems vary widely across Trusts, hampering the ability to share information and operate collaboratively at pace;
- Hidden supply chain risk - data and systems issues prevent the easy identification of points of failure (such as over-reliance on a single supplier or country). Systems used to assess risk are backward looking rather than predictive and can't keep pace with rapidly changing situations.

Through engagement with global teams, we are aware that similar work has been compared and contrasted across England and the Australian health service as part of both countries' response to the pandemic.

Approach taken

In London Nightingale, the host trust (Barts Health NHS Trust) developed an emergency escalation hub across the North East London health and care system. Work was undertaken to develop a medium term (12 month) solution, as the initial workforce, logistics and premises solutions were short term. A working group was established to rapidly engage with stakeholders across the system, manage the process, and play an active role in sourcing workforce and logistics solution. Learning from three Nightingale Hospitals (London, Birmingham and Leeds) in sourcing and supplying critical equipment, PPE and consumables indicates that taking the approach below is crucial to success:

- Step 1 - Cleanse Master Data - use of data and analytics to develop clean master data at local / regional level and enable this to be rolled up at a national level (e.g. to provide a clear view of inventory);
- Step 2 - Review and improve Supply Chain resilience - Deploy technology tools to map supply chain for critical items (e.g. PPE, consumables) to build single risk profile;
- Step 3 - Develop & implement Supply Chain technology - Implement cloud-based technologies (best of breed + health specific) to begin to automate key elements of the supply chain process (e.g. replenishment) and allow organisations to collaborate; and
- Step 4 - Implement common processes - implement a suite of standardised processes across organisations to enable better coordination on a regional / national basis

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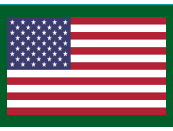
7b. Case Study	Supporting the Nightingale in England and Supply Chain and Global Learnings in Australia		

In Australia, teams also highlighted the importance of master data. A significant exercise was undertaken with an Australian state to take the 'historic' PPE list from the health service, review and expand this through engagement with stakeholders to confirm completeness and accuracy of the new list. This exercise provided a significant increase in the granularity of categories available, which supported more informed management decision-making and oversight of existing supplies.

Benefits/Lessons identified

A clear and consistent supply chain strategy is needed to enable healthcare to deliver BAU services as efficiently as possible and enable it to respond to crises like Covid-19 in an agile way. Current supply chain operating model, processes, systems, and data prevent this. There has also been a historical focus on cost rather than supply chain resilience. Benefits achieved and lessons identified from the Nightingale Hospitals in England and through global learnings from Australia include:

- Materials management system is vital
- Making 'a decision' quickly can be better than waiting for a perfect decision when working at pace;
- Clean master data is essential to provide one version of the truth for an organisation's inventory picture.
- Creating a single risk map showing key supply risks (both future and current risks) provides easy oversight;
- Develop common processes, underpinned by technology across organisations to support collaboration;
- Regional or organisational command centres specifically for PPE have worked well in England and Australia;
- Sophisticated data and analytics and visualisation outputs to model demand and supply supports operational decision-making.

8. Case Study	Use of TeleHealth to Address Covid-19 Needs in the USA	

Challenge

There are a number of challenges involved with the rapid expansion of telehealth tools in response to the pandemic. Considerations made by this Medical Centre were around how best to expand existing services, identifying sufficient resources to support both the initial demand and on-going consultations using telehealth, how best to integrate telehealth tools with existing health records and what the relevent clinical protocols and patient inclusion/exclusion criteria are to continue treating the right patients safetly.

Approach taken

As part of the response to Covid-19, relevant factors considered included:

- Establishing a governance task force with clinical, IT, administration, marketing and Access representation, with nominated champions for each area across the hospital;
- Reviewing existing cold, flu, and fever clinical and medication prescribing protocols as a basis for Covid-19 protocols;
- Worked closely with marketing teams to develop targeted and general awareness messaging to ensure patients interacted with the system in the right way;
- Rollout of training materials across identified stakeholders (beyond clinicians into access and pathway coordinators) in relevant telehealth tools; and
- Developing logistical plans for primary care, specialty care, ED and urgent care to offer dedicated 'telehealth rooms' within the organisation to promote telehealth to inbound patients.

Benefits/Lessons identified

Through engagement with this medical centre, reported benefits and impacts from engaging with telehealth were referenced as being:

- The launch of a standardised internal process across specialties using one technology platform and data management approaches that integrated with the existing platforms used;
- Alignment between wider access initiatives beyond Covid-19 response into telehealth. A team of triage nurses were embedded within a transfer centre with a focus on referrals across community providers and were able to draw on standardised clinical protocols develop for telehealth to direct patients into new pathways; and
- A well-established governance structure for telehealth to continue operating beyond the first wave response to Covid-19. As a for-profit provider, this included financial analysis and modelling to provide evidence of return on investment for patients engaging through this service.

9. Case Study	Sustaining Virtual Care in Canada	

Challenge

As with many other health organisations across the globe, this Canadian health system recognised the increased need for digital healthcare as the pandemic impacted the ability of clinicians to treat patients face to face. In addition, this organisation had not yet implemented Microsoft Teams and therefore had a significant journey to undertake, much like across the UK, to embed digital ways of working both internally and as part of new clinical pathways.

Approach taken

In order to rapidly develop new virtual care pathways, this hospital implemented a 'virtual care pilot' targeted at its respiratory clinic to ensure it would be able to meet the needs of potentially Covid-19-positive patients during the pandemic. A key emphasis was placed on the 'planning' phase of this rollout, with the hospital emphasising virtual care should be treated as if it were a new clinical service, not just a change to an existing service. During this planning phase, the hospital ensured to capture feedback from a wide group of stakeholders, ensuring that patient concerns and queries were at the centre of the design process. As part of this stakeholder engagement, involvement from data privacy teams, clinical records, and patient scheduling were all involved to provide an end-to-end assessment of the new pathway.

Benefits/Lessons identified

Working in conjunction with external advisors, this virtual care pathway has resulted in an updated digital strategy for the hospital, as well as a nine point 'action plan' for considerations on the further introduction of digital into existing services. Key elements of this action plan that could be relevant for NHS Boards include:

- Providing clear channels for patients and service users to give feedback on the process, ensuring this aligns with existing patient experience processes;
- Design virtual care into the patient's end-to-end journey. Patient expectations and cultural sensitivities must be considered when hospitals move towards virtual care.
- Build the use of digital pathways into the performance management process to help embed the change and limit the risk of reverting to previous ways of working for staff;
- Determine the impacts of where any technology or data may be held and how data will be managed. Privacy and cybersecurity processes will become more and more important as pathways become more digitised;
- Develop an awareness and marketing programme for patients and service users which aligns to organisational targets. Service redesign requires patient involvement and specific segments of patient groups should be targeted using different awareness strategies.

10. Case Study	In-House Communications during Covid-19 in England	

Challenge

Similar to all organisations during the pandemic, this Trust had to consider how best to communicate with staff to provide them with enough, regular information without overwhelming teams. This involved responding to national guidance as well as providing a source for any staff and family queries or concerns. These challenges covered:

- The postponement and eventual restart of elective activity;
- Patient and family anxiety around delays to accessing services; and
- Staff working remotely

Approach taken

The organisation had previously created a Communications Strategy for 2020, but with the unpredictable environment facing the communications team, this was rapidly reviewed and updated. To react to this changing environment, the team moved to providing a 24/7 press office, with a shift pattern introduced to ensure appropriate coverage of any incoming requests seven days a week. The team also created a series of new resources and materials for staff and the public, while holding different forms of engagement sessions to provide additional information. These included:

- A daily communication issued to staff via 'all staff' mailing lists;
- The launch of an internal Covid-19 Information Hub with over 550 documents available;
- Regular 'Live' broadcasts on MS Teams with over 700 questions answered and a maximum attendance of over 1,000 staff members at once;
- A 'Stay Safe' campaign using large-scale, social distancing floor vinyls, posters, leaflets and banners. This has subsequently been shared with other Trusts in the region with elements being adopted nationally;
- A Covid-19 Public Information Hub, being a single platform for all resources for the public which included visiting details, family support, helplines, education, FAQs and a 'fun' section for children. This has had over 30,000 views; and
- A dedicated 'Coronavirus for Kids' campaign to help reduce anxiety in young people; explaining what the virus is, how it is transmitted and reassuring young people that it isn't their fault if someone they know catches the virus.

Benefits/Lessons identified

The communications team involved were nominated for national awards for communications during the pandemic, and won a Special Award from the Corporate Communications Magazine for their innovations and efforts during the pandemic.

The communications were also well received by staff and patients, with feedback including:

- "Communications truly bring everyone together, and [this approach] has provided rapid and accurate information in a time of constant change" - Staff member (consultant)

10. Case Study	In-House Communications during Covid-19 in England	

- "If it wasn't for the communications team and the support they've given us at an overwhelming time, we'd have been completely lost" - Patient family member
- "They [the team] have supported the delivery and cascade of ever-changing information, provided supportive resources, delivered care packages to the most vulnerable staff and so much more' - Staff Member

11. Case Study	NHS Foundation Trust – Working to a shared vision in England	

Challenge

Facing significant competing priorities across regulatory and operational requirements, this NHS Foundation Trust sought to streamline its priorities and make targeted efforts to improve performance in a more meaningful way in a smaller number of areas, rather than trying to improve slightly across a wider range of objectives.

Approach taken

With external support, this Trust sought to:

- Identify a small number of strategic goals to focus on, and create a system to cascade these priorities throughout the organisation to ensure all efforts at all levels were aligned;
- Developed a specific room where performance data was displayed on the relevant metrics. Meetings were scheduled to take place in this room with a multi-disciplinary team to ensure any barriers to problem solving were mitigated;
- Coach frontline teams in a series of skills and tools, as well as a change of mindset, to empower staff who work closest with patients to solve problems they come up against and to embed continuous improvement into daily working;
- Deploy daily 'huddles' within wards and corporate teams for a short, focused meeting on identifying and solving problems. Escalation processes were aligned so these huddles would happen at all levels of the organisation; and
- Realign existing performance management processes to ensure more focus was placed on those areas that were deemed to be relevant for the Trust's strategic priorities.

Benefits/Lessons identified

We note this work is not based on an organisational response to Covid-19, but emphasises key messages raised in document reviews and consultations around the importance of aligning to a few, key tasks rather than tackling a larger number of tasks with less resource and effort. In deploying this approach, the organisation here:

- Had dramatically increased staff engagement scores in all departments;
- Had a 30% reduction in patient falls within three months (one of the strategic priorities);
- Had an 18% increase in theatre start times and 25% increase in breast surgery cases per list;
- Had planned to close 17 out of 34 weekly theatre sessions due to efficiencies, releasing a cost pressure of c.£800k; and
- Was rated 'Outstanding' in all domains by the Care Quality Commission in its latest inspection.

12. Case Study	NHS Nightingale – Workforce in England	

Challenge

As part of the national response to the pandemic, the Department of Health and Social Care commissioned a series of 'Nightingale' field hospitals to provide additional surge capacity for either the treatment of high acuity Covid-19 patients, or for convalesence to release existing ICU capacity within local providers. In doing this, additional workforce was required to staff the field hospitals while providers locally were facing challenging workforce planning within their own hospitals.

Approach taken

A number of steps were taken as part of the response to ensure there was sufficient staff available within the field hospitals. These included:

- Aligned with national approaches to reduce staffing ratios for critical care nurses, moving away from 1:1 care towards a 'team-based' approach whereby additional support was provided by non-specialist nurses and healthcare assistants to make the best use of critical care nurse capacity;
- Early agreement of multi-disciplinary team requirements, with sign off from senior clinical leaders across nursing, medicine, pharmacy, allied health, and medical engineering to confirm appropriate staffing ratios for a set number of beds for anticipated pathways;
- Distillation of key skills within each of these roles, with requests for additional support aligned to the skills most needed rather than those roles.
- A daily update of roles to be filled mapped against existing supply of staff, with the number of beds to be opened capped at the maximum supply of safe staffing ratios available. Additional supply was sourced through 'returners' (recent retirees and medical professionals who had recently left the NHS), with a tailored programme of training and onboarding developed to ensure clinical teams were able to meet the agreed skill-mix as approved by senior regional leads; and
- A modelling approach whereby existing headcount across local hospitals was weighted to the total requirement, with hospitals providing staff to the central field hospitals in a proportionate manner. Where any shortfalls were identified, local commissioners and other sources of supply (e.g. volunteers) were engaged to provide additional staff.

Benefits/Lessons identified

At the time of the field hospital being required to open, sufficient staff had been identified to safely support the treatment of the first wave of beds. Training needs and skills mix analyses had been carried out, and a handover of the daily mapping model used to inform the demand modelling.

13. Case Study	‘Team Time’ Initiatives in Ireland and England		

Challenge

Recognising the challenges faced by staff during Covid-19 and the barriers that social distancing might have on being able to obtain personal support within the workplace and outside of this as existing support networks become broken down.

Approach taken

Building on evidence-based 'Schwartz Rounds' as a tool for emotional support within health and Social Care, this organistion supported over 500 people across the NHS in England, HSE Ireland, children's care centres and hospices to become trained in how to implement and run 'Team Time' in their organisations. Team Time is a 45 minute reflective practice that is run and facilitated online to provide staff members with the space and opportunity to share experiences of their work. The audience is limited in size to ensure small groups are able to focus on their emotional and social response to existing work conditions, and this became particularly important during Covid-19 as staff found themselves under significant amounts of pressure. These sessions were facilitated online to allow easy access for teams who might work in community or non-ward settings, and are centred around volunteers telling stories about their experiences and welcoming other attendees to reflect on their experiences alongside this.

Benefits/Lessons identified

This organisation captured qualitatitive and quantitative data from feedbacks to understand the impact of holding these 'Team Time' sessions. Key findings from this quantitative data include:

- 85% of respondents felt the sessions either somewhat or completely made them feel they would work better with their teams;
- 89% of respondents felt they gained insights from the sessions to make them feel more calm and supported back in their day-to-day role;
- 94% of respondents felt they had a better insight into how members of their team felt about their work.

Participant feedback included:

- "[I] Just found it so supportive hearing and knowing that colleagues are facing similar challenges to me and that I am not alone with this struggle."
- "I think it is probably singularly the most important thing we have done for our staff mental and emotional wellbeing during this whole period."
- "Anything that is providing an opportunity for staff to reflect on and to share the emotional impact of work is just invaluable really, and is invaluable for the ripple effect for them to be able to deliver compassionate care".

14. Case Study	Welsh Health Board – Findings on Governance in Wales	

Challenge

As with other health and Social Care organisations, this organisation recognised the imminent challenges of responding to the pandemic early in 2020, and devised new governance structures accordingly to provide for as much planning time as possible in advance of the full onset of the first wave.

Approach taken

As expected during the pandemic, the organisation rapidly mobilised. A Covid-19 'tactical group' was initiated as early as the 3rd of February with an informal bronze structure starting to be constituted on the same day. In the following month this tactical group focused on redesigning pathways across community care and paediatrics and working through the relevant workforce challenges this presented. Involvement from the finance team was formalised in late February. Bronze command was formalised on the 4th of March with focssued groups covering community care, primary care, Acute care and workforce to provide clear operational oversight of these areas.

Benefits/Lessons identified

Early planning has been cited as a key driver for a more efficient response. Having consulted with staff members involved in the first wave however, this organisation identified the following lessons. These cover both things that staff members reflected positively and negatively from the newly-constituted governance structure, and may serve for guidance for Scottish Government over the coming weeks and months:

- Staff felt having a clear structure worked well, everyone knew when the meetings were happening, who was involved in the meetings, and how decisions would be made;
- There was a specific focus on the Bronze groups as being 'problem solving' areas. The thematic nature of these groups meant problems were first escalated here and could be solved rapidly without further escalation; and
- Staff cited the fact that the framework of the command structure provided autonomy and 'freedom to act'. Decisions did not need detailed reports, and a multi-disciplinary membership on the command meetings meant that local decisions were made by local teams.
- There was however a feeling that Bronze teams were not necessarily connected with each other. Being organised by care group meant that while each group was able to act as a specialist in its own area, this created an element of 'silo working' and limited the ability to join up across pathways; and
- Some people noted a disconnect between Gold decisions and frontline delivery which impacted the ability for frontline teams to act.

15. Case Study	NHSE Elective Service Restoration in England	

Challenge

The Adopt and Adapt programme is one of a number of key initiatives established to increase the pace at which the NHS in England recovers from the elective backlog. There are a number of challenges in recovering activity that are consistent across systems globally, and in this context the programme specifically considered:

- Delivering activity with revised Infection Protection Control measures;
- A backlog of demand from the pause of routine work during Phase 1, which resulted from changes in Public Health-seeking behaviours, access to primary care and referral services, and access to secondary care; and
- The available workforce capacity to continue to respond to the pandemic and increased planned activity while taking enough rest and recovery in order to maintain a sustainable response.

Approach taken

Adopt and Adapt focussed on five key service areas/pathways within planned care: Endoscopy, CT & MRI, Outpatients, Theatres and Cancer. The programme then worked with one region for each of these pathways to:

- Quantify a specific objective (defined broadly as the gap between pre-Covid and current activity levels);
- Run rapid problem-solving workshops with Subject Matter Experts, regional and national stakeholders, and clinicians to brainstorm 'big ticket' solutions that could be implemented rapidly;
- Complete further regional engagement with systems and frontline teams to refine ideas, develop system-level plans and establish a standardised programme approach;
- Share 'blueprints' from each of the five regions across the remaining regions to share best practice and solutions.

To take the example of the Endoscopy programme (focused on NHS London), specific interventions identified to support the immediate recovery of capacity included:

- Splitting upper and lower GI lists to boost productivity of lower GI (as upper GI 'aerosol-generating' procedures required additional IPC requirements;
- Expanded use of trans-nasal endoscopy and CT Colonoscopy;
- Region-wide sessional rates agreed for Waiting List Initiatives to encourage evening and weekend work;
- Role redesign to explore clinical support workers being redeployed to allow clinical teams to operate at the top of their licenses;
- Immersive training programme for ST5-7s and a targeted CT Colonoscopy training course agreed with Health Education England to increase the number of endoscopists able to practice independently.;
- Passporting arrangements across the system to allow endoscopists to work in multiple settings; and

15. Case Study	NHSE Elective Service Restoration in England	

- Maximised use of the independent sector for additional capacity (up to 32 rooms).

Benefits/Lessons identified

Based on the above approach, specifically looking at the actions within Endoscopy, the following benefits were achieved:

- Data shows activity in London at 90% of historic levels (believed to be underreported and actually closer to 100%);
- 5,000 procedures being completed a week; and
- Daily reporting showing the waiting list having declined by 16% from the peak (start of September 2020).

Wider benefits include the creation and agreement of new, region-wide governance structures for diagnostics, supported by pan-regional Clinical Reference Groups. Systems within London are also forming further networks with clinical leadership to further integrate across organisations.

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