The University of Manchester
Alliance Manchester Business School

Health and Care: The challenges of system recovery from COVID-19

Introduction

COVID-19 has affected populations and individuals (people) – whether directly or indirectly. Compared to previous pandemics its effects are more far-reaching, and recovery will be not only focused on physical and mental health but also on the system; economic, infrastructure, the environment and wider humanitarian issues. We focus here on the challenges for the health and care system in the UK using the lenses of people, place and processes, which are underpinned by partnerships and power.[1] We show that recovery on health and care systems alone will not be sufficient to address the impact of this pandemic, and highlight the challenges for the health and care system.

People

Much of the focus within the English health and care system is now on 're-starting' services which were either paused or severely reduced during the peak of the pandemic. But 'service' provision may not be focused on the multiple and complex needs of *people* – particularly those with multiple conditions.

For example, emergency and urgent care services will continue to be delivered and restored to full function, for example for frail and elderly *people* who fall at home and require treatment. However, there may be issues with restoring linked services e.g. risk assessment and services to prevent future falls, or mental health assessments. In addition, services for the same group of *people* requiring additional (planned) services, such as hip replacements, cataract removal, may not be restored so quickly, partly due to the difficulty in ensuring ongoing operational social distancing in clinical settings, the redeployment of staff, as well as ensuring the ongoing supply of blood and medical stocks. These planned services not only are provided to help people return to health, but also improve quality of life and prevent further worsening of overall health and wellbeing. Long periods without such services may drive emergency and urgent care demand further, whilst the number of people on waiting lists grow.

Services may also not focus on *all* the needs of those who have been affected by COVID-19. For example, there is increasing evidence of the requirement for longer-term physical rehabilitation for those who have experienced COVID-19, as well as likely demand for mental health support. The mental health consequences for staff that have been involved in care provision are also likely to be significant. New support needs may also emerge during the recovery phase of the crisis such as economic strain leading to further unemployment, homelessness and mental health needs. In addition, health and care needs are already increasing e.g. from those subject to domestic violence or letting their health decline further during lockdown rather than seeking treatment.

The challenge is ensuring that system recovery is focussed on the holistic needs of *people* requiring care, rather than a fragmented restoration of health services that prioritise clinical emergencies and may leave gaps in the support available for the total health and care needs of the population, not all of which can be addressed by the NHS.

[1] De Savigny, D. & Taghreed, A. (eds.) (2009) Systems thinking for health systems strengthening. Geneva: World Health Organisation

Dr Joy Furnival and Professor Ruth Boaden

Place

Within the English NHS a developing vocabulary of 'system', 'place' and 'neighbourhood is being promoted[2]: System (~1-3m people); Place (~250 - 500,000 people) – often a local authority area; Neighbourhood (~30-50,000 people). Our interpretation of the term '*place*' is broader than this and relates to the local context where people live and work (neighbourhood) as well as within local authorities. Much of the activity during the response to COVID-19 has been at a 'place' level (as defined above) and then determined in detail, enacted locally and adapted to the local context. This 'bottom up' approach and local adaptation will be a challenge to maintain as response reduces. Within a place there appears to have been success in:

- Community connections, collaboration and support: there has been an immense contribution to date from "*general public and schools sewing scrubs and making visors, through business donating equipment, to community organisations offering extraordinary support*"[3]
- Working across organisations. There are numerous anecdotal reports, and evidence from interviews we have been conducting, of working together as never before in local networks and without organisational affiliations being a barrier to this. Our contacts suggest that this success has been at least in part due to less restriction from/impact of:
    - Information governance rules – information has been shared when deemed appropriate across organisations
    - Finance – less concern about limited financial resources or consideration of whose budget funding might come from
    - Central guidance – especially at the level of guidance on 'how' to do things
    - Regulation – reduced paperwork, inspections and assurance requirements
- Such inter-organisational working is also reported to have been established quickly in places where there was already a history of working across health and other organisations, in particular with local authorities. It is likely that the extent, scope and speed of partnership working has been heavily influenced by the place and by the history of such partnerships previously and it will be important to build on this during recovery.

Response to and recovery from COVID-19 has brought into focus the lack of alignment from the English government in terms of place (see Table), and this must be taken into account in recovery. There are other government departments (e.g. the Environment Agency[4]) who have other place definitions – these two are used here because of their crucial role in recovery.

Local Resilience Forums (LRFs)	Sustainability and Transformation Partnerships (STPs) - NHS
"*multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others … aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities*"[5]	"*partnerships [NHS organisations and local councils] … to run services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents' day-to-day health.*" [6]
▪ 9 regions	▪ 7 regions (in England[7])
▪ 38 LRFs	49 STPs – of which 18 are now designated as Integrated Care Systems[8]

[2] https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf

[3] https://beckymalby.wordpress.com/2020/05/05/what-do-you-want-to-keep-from-this-time-lessons-for-the-nhs-dont-let-the-old-world-bite-back/

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/550194/Natural-England-offices.pdf

[5] https://www.gov.uk/guidance/local-resilience-forums-contact-details#history

[6] https://www.england.nhs.uk/integratedcare/stps/view-stps/

[7] There are also 3 devolved administrations (Scotland, Wales and Northern Ireland) who are not part of this structure

[8] https://www.england.nhs.uk/integratedcare/integrated-care-systems/

The challenge is that there is no single English government notion of place, since national structures are different depending on the lead department, and do not align. Effective partnerships for recovery need to develop at *place* level, despite this lack of alignment and may be best led by local authorities given their responsibilities for a range of vital services for people and businesses in defined places. . There is a clear link between place and working in partnership (see following section).

Partnerships

So far, much of the focus of the COVID-19 response has been in the health setting and within the hospital sector. However, the emphasis is rightly now shifting to other sectors, as recovery from COVID-19 will need to involve much more than just 'health' services. Local authorities from metropolitan districts and boroughs to county councils, as well as district councils[9] have been absolutely critical to tackling the spread of coronavirus. Every day they maintain crucial services. They have set up community hubs and have built on existing local teams. They provide food and shelter to people at risk, help local businesses stay afloat and have mobilised volunteers on a scale we have never seen before.

In particular, in the short and longer term, control of COVID-19 will depend on social care provision. In particular, the role of care homes, both residential and nursing, and the provision of care in the homes of those who are vulnerable, which has gained prominence during the pandemic. Prior to this there was already a documented "crisis" in social care[10] which has arguably been underfunded for many years. Whilst additional support for care homes to support the COVID-19 response has been provided[11], a more sustainable solution to the sector will need to be found to ensure the sector can withstand both second and subsequent peaks of the virus and future novel pathogens, whilst ensuring the delivery of high quality, compassionate care to their residents and service-users.

A mechanism for recovery with this increased focus on the wider health and care system could be through STPs and Integrated Care Systems (ICS) across regional footprints. Whilst the government's ambition of all NHS areas being Integrated Care Systems by 2021[12] may have seem ambitious, COVID may have helped to support the development of these partnerships.

"In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve"[13]

There are calls for national guidance on "*when and how systems should make decisions on new ways of operating"*[14] and a recognition that there is a key role in this for local government: this is not only a 'health' issue. These non-statutory bodies (ICS) already contain leaders from different roles and organisations within geographical places, such as from the voluntary and emergency sector, councils and healthcare, and seem ideally positioned to help take up regional partnership delivery of the ongoing local recovery, provided the non-alignment at regional level with other civic emergency response partnerships can be addressed.

Process

Process concerns all the activities that occur in response and recovery – and many of these cross organisational boundaries. Essentially this is about 'how' things are done.

[9] https://www.gov.uk/guidance/local-government-structure-and-elections

[10] https://www.health.org.uk/news-and-comment/blogs/what-should-be-done-to-fix-the-crisis-in-social-care

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879639/covid-19-adult-social-care-action-plan.pdf

[12] https://www.longtermplan.nhs.uk/

[13] https://www.england.nhs.uk/integratedcare/integrated-care-systems/

[14] https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/REPORT_STPs-one-year-to_go_FNL.pdf

It is clear that many processes during the response phase have not worked as well as many would have liked: For example:

- PPE/supply chain management and distribution. Military experts were brought in to support this process and criticised the efforts of the NHS[15]
- Testing for COVID-19, which has been a matter of contention since the start of the pandemic
- Tension between central control and locally-designed and led initiatives.

Another aspect of processes, which follows from the place and partnership issues already outlined, is the difference in the availability of measurement data for COVID-19. Reliable, trustworthy data on COVID-19 has been sparse and difficult to collect frequently and in real-time outside of hospitals such as in community, social and primary care or home-based settings. Most national tracking data and regional dashboards for COVID is either available at a population level or only for hospital sites, meaning that the 'current state' is always biased towards acute provision, lagging and under-estimated – death reporting is a case in point.

Other data, for example, routine waiting lists for surgery have been less visible during this crisis although waiting lists were already over 4 million people with some waiting over 1 year prior to the pandemic, which will have exacerbated that further. Routine screening, dental checks and vaccination services have all but stopped but this data is currently under little scrutiny, not have the long-term implications of this for population health been highlighted.

Despite this many care processes have been newly established and seem to have worked well during this crisis. For example:

- Hospital discharge processes were able to enable the discharge of very long staying hospital patients quickly, having previously been unable to do so. There is learning from this for improved patient discharge, but also a requirement to consider the impact of e.g. insufficient support arrangements, should patients be discharged too quickly.
- New shift patterns and new ways of delivering clinical training have been established quickly
- Many clinical appointments in primary and secondary care have shifted on line or over the phone
- E-prescribing has increased in uptake rapidly despite being available to many for a number of years.

It could be that this sudden uptake of new ways of working and the establishment of new processes has worked well because of the clarity of purpose and shared aim of addressing COVID-19 – a political and moral imperative. This may have been supported by the limited dataset and performance criteria, focused only on COVID.

The challenge is how to ensure that the new operational processes are retained when they have been found helpful, ensuring that these are evaluated well, and identifying where old processes need to be re-established, and when.

Power

In the first few weeks of the immediate response to COVID-19 we saw the NHS enact its pandemic plan, which incorporates a significant role for local and pseudo-regional (mega-) hospital providers under national direction. This makes a lot of sense; the need to step up hospital based critical care capacity was urgent and large-scale field hospitals needed to be established and staffed.

The need for a centrally (government) driven approach to response initially was at odds with the prevailing policy direction, although entirely appropriate at the time and supported by emergency legislation. The NHS Long Term Plan[16] was being implemented and was underpinned by a shift away from acute providers towards community resources and provision. In COVID-19 response however it seems that resources were

[15] https://www.thetimes.co.uk/article/military-appalled-by-planning-fiasco-over-nhs-protective-kit-jdh369k6r
[16] https://www.longtermplan.nhs.uk/

needed to flow in precisely the opposite direction. Large acute NHS providers led the way, mobilising their networks and relationships for local delivery. Whilst this was arguably a pragmatic choice, other local organisations and their relationships may have seen their power diminished. For example, clinical commissioning groups (CCGs[17]) whose role is "*deciding what services are needed for diverse local populations, and ensuring that they are provided*", had their power significantly reduced when emergency orders were imposed allowing NHS England to direct local commissioning powers[18], rather than reinforcing the role of CCGs in protecting the public and ensuring health of local populations. . It is as yet unclear whether the policy of increased focus on out of hospital services will continue, and whether CCGs will have their local powers reinstated in due course, although it remains the policy of the NHS in England as described in the NHS Long Term Plan.

The NHS needs to 'recover' some health services whilst still maintaining the ability to respond to cases of COVID-19. This highlights one of the key 'power' issues in the NHS - the NHS is not a single organisation, but a 'brand' used by a range of organisations - some wholly public sector, others hybrids, third sector or private independent operators - often collaborating together to support patients but sometimes competing for resources, reputation and using their financial or operational power in this. For example:

- One hot topic of discussion at present is the need to reconfigure hospital sites as COVID-19 positive ''hot' sites or COVID-19 negative 'cold' sites. Large acute providers and regional bodies may choose to reconfigure services in line with their longer-term strategic goals that may strengthen or re-establish as a priority specific care treatments and pathways for patients. However, these may not be aligned with local community wishes, and may not deliver optimum clinical outcomes for patients suffering with COVID-19 or other conditions due to existing care delivery inequalities[19]. The 'power' of size and influence of providers over the configuration of services across an area may be exerted here.
- The longer-term risk of reconfiguration options such as these is that whilst at present these seem sensible, pragmatic choices, how will such service reconfigurations be 'undone' later, if such reconfigurations do not serve wider population interests? They may increase inequity or drive poorer clinical outcomes. The operational choices enacted now may have long term consequences, both positive and negative, for care delivery for populations. Little public consultation (if any) has been conducted, despite it being a legal requirement for significant reconfiguration of healthcare services[20].

It is also important to ensure that, as other health and care services resume, choices are made transparently and consistently about who is treated (and who isn't) given the limits of space, equipment, supplies and staffing. These choices are likely to be different for different populations and community partnerships may be significant in locally and regionally negotiating and agreeing these process priorities if they are permitted to exercise their power in this context.

The challenge is to ensure that the power of all parts of the health and care system, including the public, is recognised and can be exercised as recovery is planned. The longer-term consequences of decisions about service provision made as part of the COVID-19 response must be considered since some cannot be easily reversed.

[17] https://www.england.nhs.uk/ccgs/

[18] https://www.hsj.co.uk/commissioners/nhs-england-takes-over-ccg-powers/7027203.article

[19] https://www.nuffieldtrust.org.uk/news-item/poorest-get-worse-quality-of-nhs-care-in-england-new-research-finds

[20] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

The challenges

The challenges of recovery are not only about health and care but about society as a whole.

- We need to focus on *people* and their holistic needs; this scope is broader than the provision of NHS services and involves local authorities, the third sector and others.
- We need to align recovery in a *place* that makes sense to the people and builds on how response to COVID has worked; rather than following administrative boundaries for the NHS or any other department.
- We need to consider recovery of the whole system and work in *partnership*; this must include the voices of people as part of a system-wide approach encompassing health, care and wider public sector organisations.
- We need to consider all *processes* within and across organisations; evaluating where they have worked and retaining them, and questioning the re-introduction of others.
- We need to ensure that the *power* of all parts of the health and care system is recognised and can be exercised; considering the longer-term consequences of decisions for society as a whole rather than only for the convenience of the NHS.

Recovery is not only an NHS, or a hospital, or a health issue, nor even a health and 'social care' issue. It is something for the whole system – which must include people who live and work in places and communities – and it is imperative that all parts of the system work in partnership, building on the way in which response to COVID-19 has broken down barriers and enabled new and improved processes.