The Frontline Collaboration against COVID-19: Briefing to Health and Social Care Committee

Introduction

The Frontline Collaboration Against COVID-19 (FCAC-19) is an initiative set up on March 15th 2020 in response to the growing and recognised need for stronger coordination in support of frontline health workers, as well as the need to involve them more closely in developing solutions for the healthcare challenges they face. In acknowledgement of the overwhelming task that this crisis presents to the NHS, as well as the recognition of the UK being a global leader in humanitarian disaster response, the FCAC-19 brings together frontline NHS staff and humanitarian experts, supported by NHS institutional leaders.

The group strongly believes that without assessing and understanding the needs and experiences of those directly involved in care delivery, guidance and decisions made by national bodies will fail to have the intended service impact.

In addition, policies, pathways and procedures are being developed across multiple hospital trusts to address the challenges of COVID-19, leading to a duplication of efforts with a lack of standardisation of care, and hence missed opportunities to share good practice, or to ensure that patients have equitable access to care.

The international humanitarian sector has learned a great deal from the experience of trying to saving lives and reduce suffering following large scale humanitarian crises such as epidemics, conflicts and natural disasters over the last 30 years. When recognising that what we are facing both nationally in the UK, as well as globally, is not merely a 'health system' problem, but rather a humanitarian crisis, we begin to appreciate the opportunity to translate and adapt principles of humanitarian practice to better serve the needs of our population in the UK.

As such, the three core aims of the group include:

1) Bridging the gap between the needs of frontline staff with that of health policy and practice influencers in England in order to ensure rapid adoption, and implementation of an impactful response.
2) Improving collaboration between practitioners and institutions through sharing of knowledge and learning so to support scale and standardisation of good practice.
3) Bringing together humanitarian learning relevant to this crisis in terms of a needs-focused, stakeholder-managed and solutions-driven approach.

We fully acknowledge and appreciate the tremendous efforts of all those involved in preparing and responding to this unprecedented crisis. However, in light of the ongoing UK Parliamentary Inquiry into the Management of the Coronavirus Outbreak, we wish to highlight some of the critical challenges faced by the current approach to preparedness and response, in addition to opportunities to strengthen operational delivery of care. By modifying the current approach, a number of outcomes could be achieved, including:

- Improved operational decision making and activities across the health care system from NHS bodies to hospitals and Clinical Commissioning Groups.
- Improved physical and mental health of NHS workforce, including retention in roles.
- Improved patient outcomes, particularly in high risk and vulnerable patient groups by ensuring the health needs are identified and addressed.
- Improved community engagement to support population health and wellbeing initiatives.

NHS Priority Challenge 1: The Management and Coordination System

The current medical response to COVID-19 by the NHS follows a tiered Major Incident Management approach of Bronze (Operational), Silver (Tactical) and Gold (Strategic). It is a system designed to manage mass casualty incidents such as a bus crash or bombing event, which require a time-bound response and involve a temporary upsurge in health delivery capacity for hours to days, focused at one or a group of hospitals, but not nationwide. Each tier is reliant on appropriate and relevant communications to inform dynamic planning and response. This system has been adapted for use in a pandemic, of which there is very limited evidence or experience in terms of its utility or relevance for such a context. Previous large-scale simulations in the UK such as the Winter Willow (2007) and Operation Cygnus (2016) exercises failed to demonstrate successful responses. Examples of healthcare systems which use similar disaster response frameworks (such as Canada and Taiwan) have published a range of lessons learned[1] in response to the SARS outbreaks of 2002-2004. These exercises highlight the significant challenges and failings of traditional institutional approaches to outbreak response.

In the UK's response to COVID-19 so far, the incident management approach has resulted in a hierarchical and siloed approach to decision-making and care delivery at the frontline. The following are some of the consequences:

- Uneven preparation and response with duplication of work.
- Poor coordination across health service sectors (within hospitals, community care as well as the wider public health response).
- Limited opportunities for collaboration or decentralised planning for tailored local service delivery.
- Inconsistent communication and support for frontline staff, with a breakdown of trust between staff and managers.
- The relative absence of inclusion of frontline carers or communities in decisions of care priorities and access.

Examples that highlight some of the consequences of the incident management approach include:

[1] For example: https://www.sciencedirect.com/science/article/pii/S1201971204001766 and https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/publicat/sars-sras/pdf/sars-e.pdf

- Preparation and response that favours large regional teaching hospitals which have capacity and resources to mobilise and redeploy staff, contrasted with smaller district hospitals where daily surges in clinical demand overwhelms their ability to plan and respond, which perhaps could have been supported by extra shared resources from regional sites.
- High levels of anxiety amongst frontline staff caused by situations where they are made to modify their ways of working (such as use of PPE, referral and admission pathways, supervision support) as well as the teams and locations they are used to working in, but where plans may change sometimes on daily basis, and without any explanations provided.
- Lack of structured feedback and situation reporting resulting in service challenges and opportunities being missed, such as issues of oxygen flow through a hospital to manage ward bays, or the utilisation of staff having to work from home due to health risks, or varying visiting policies for relatives of the terminally ill.
- Communities who have organised to develop their own responses to perceived needs, (such as a mosque-hospice initiative in Bolton, or multilingual advice services) but which aren't integrated within the national response.

Applied Humanitarian Learning Recommendation 1

Strong coordination at all levels is recognised as one of the key pillars of ensuring a dynamic response to a complex emergency. The mechanism utilised internationally is termed the 'Cluster Approach'. This aims to provide system-wide leadership and accountability, strengthens partnerships between government and non-government responders, supports prioritisation of actions as well as promoting joined-up working across disciplines and sectors. Developed and supported by the United Nations Inter-Agency Standing Committee, the approach works to ensure operational and strategic gaps are actively assessed and analysed through its partners, with interventions applied and results monitored for impact. It is an approach that can work in a facilitated way alongside national mechanisms rather than replacing or competing with them by providing extra capacity to coordination and response functions.

By focusing on the coordination of a range of diverse actors beyond government (including charities and community organisations), lateral sharing of information, putting in place simple standards, as well as ensuring accountable learning from mistakes, the methodologies employed within the cluster approach have a significant role to play in addressing the weaknesses of the incident management mechanisms being currently being utilised by the NHS.

Operationally in the UK, such an approach could occur at central, regional, local and facility levels, where capacity to deliver coordination functions could in part be delivered by re-purposing and combining existing health and social care personal and technology resources, and supported by additional investment to facilitate core activities. Two key outputs would include the establishment of coordination hubs, and a coordination platform.

Coordination hubs

In the first instance, coordination functions could be established as hubs within the hospital settings to support incident response, as well as in the community to support Clinical Commission Groups (CCGs) to better define and engage with stakeholders and partners, understand activity and needs, drive solutions and improvement, as well as enhance communication and collaboration. Such coordination hubs could additionally develop tools for supporting standardised collection of relevant data which would in turn support localisation of response and equitable resource distribution as oppose to reporting upwards to await for central guidance.

The key barrier to establishing such hubs is the structured incident management approach which dictates who has responsibilities for reporting and decision-making, and excludes inputs from other important sources.

Coordination and knowledge platform

Currently, doctors and nurses may have to review multiple sites in order to identify relevant information, such as the resources on the NHS England website, those hosted on government sites, information on specialty and profession-specific sites, as well as their own hospital sites for updates including multiple emails a day, in addition to identifying learning, training and wellbeing resources. If these sources do not address their knowledge gaps, healthcare professionals are having to use social media sources.

The development of a user-centric platform to collate and curate information, guidance, research, toolkits and learning support resources would help limit duplication of efforts and greatly support frontline health care workers, as well as hospitals and primary care networks to better deliver care. This knowledge-sharing approach would have also have global benefits. In the humanitarian sector such as www.reliefweb.int and humanitarianresponse.info are used to host content in a similar way.

NHS Priority Challenge 2: Service Delivery

In response to COVID-19, there has been a dramatic reconfiguration of health service delivery, with changes to non-essential care provision, and a focus on emergency, respiratory and intensive care. Whilst there has been broad-based national guidance and practice principles issued by NHS bodies (NICE, Public Health England) Royal Colleges and Faculties, due to the management system adopted as described earlier, there has been limited direct uptake of these guidelines, which often need further adaptation and interpretation before they can be implemented by frontline healthcare workers.

In addition, due to the urgency and progression of the situation on the ground, local planning occurs reactively, often without timely joined up inter-disciplinary engagement, in a fragmented fashion and not always with consideration of vulnerable or at-risk groups. This also exacerbates the pre-existing weaknesses in service delivery with regard to patient and community centred approaches.

Specifically, in relation to health information and communication, the NHS has a range of key services and quality indicators established centrally for national implementation. Due to the variety of electronic health information systems present throughout NHS hospitals, there are differences in how such information is then gathered, distributed, analysed and reported. Most hospital processes are geared around monitoring of nationally agreed indicators as opposed to generating additional metrics that would be meaningful for local needs. Such data is usually shared 'upstream' through managerial tiers, with little input or engagement with frontline staff.

At this time, it would support the delivery of frontline care if additional metrics, agreed with frontline staff, were generated. However, there have been limited changes to reporting and monitoring systems in this current crisis which could transform the way we respond both locally and nationally to COVID-19. In addition, we need to identify ways to integrate insights and data from social media and community forums. At the community level the experience of care can rapidly become and issue of concern in its own right. It is clear that traditional ways of managing health information and communication risk being blind to core challenges of this dynamic and rapidly evolving crisis. There have been examples in the Asian community where elderly patients are refusing to attend hospitals for fear of dying in isolation, and where the belief is that all patients die in hospital given the negative media around COVID-19 hospital outcomes.

In summary, there is a critical need for information to be more focused on issues of frontline operations and surveillance, greater transparency of how local decisions are made based on information, and a greater need for tailoring the response and improving resource management both regionally and nationally.

Applied Humanitarian Learning Recommendation 2

A further pillar of humanitarian practice is the need to maintain core standards, principles and commitments of quality and accountability in delivering the response. The Sphere Handbook, developed from the tragic humanitarian failures following the 1994 Rwanda Genocide, and now in its 4th edition[2], is a core reference for practitioners involved in planning, managing and implementing humanitarian response. The standards outlined overarch across all sectors, but importantly are driven by a focus on the active determination of the needs of communities and people affected by the crisis. These principles of action, which are also linked to monitoring and evaluation indicators, seek to ensure that the response is:

1) Appropriate and relevant
2) Effective and timely
3) Strengthens local capacities and avoids negative effects
4) Based on communication, participation and feedback
5) Welcoming of and seeks to address complaints

[2] https://spherestandards.org

6) Coordinated and complementary
7) Continuously learning and improving
8) Supportive of staff to their job effectively and treated fairly and equitably
9) Responsible in how resources are managed for their intended purposes

When reviewing current NHS and hospital plans against such core commitments, it is apparent that certain principles are often being neglected, such as the response to complaints, the strengthening of local capacity, or importantly the staff support.

In reference to the health sector in particular, humanitarian learning emphasises minimum considerations for the health system across themes of:

- Service Delivery
- Workforce
- Essential Medicines and Medical Devices
- Health financing
- Health information

The FCAC-19 group developed a guideline appraisal framework based on these domains and their sub-categories in order to benchmark guidance issued by NHS England relevant for the COVID-19 response. When reviewing standard operating procedures such as those issued for accident and emergency, it was found that many key aspects were not considered or only partially addressed such as guidance on:

- the discharge arrangements for patients
- the management of the deceased
- mechanisms for sharing of healthcare workforce data and readiness to support local needs
- handling and quality assurance of donated items
- the establishment of early warning and monitoring scores

In addition, it is well recognised in humanitarian disaster settings that certain essential healthcare elements need to be further emphasised and prioritised to ensure equitable and accessible care, and that vulnerable groups are not left behind. These are outlined in the Sphere guidance through a framework across:

- Communicable disease
- Child Health
- Sexual and reproductive health
- Injury and Trauma Care
- Mental Health
- Non-communicable disease
- Palliative Care

Due to the suspension of the Tariff Payment by Results system, as well as delay to the NHS People Plan, and target review, there is a significant risk that due to the overbearing focus on COVID-19 response, other aspects of essential care are neglected. The essential healthcare elements outlined above can support a more strategic focus on core priorities while response and recovery plans are implemented.

As such the three key actions in which the health service response could be strengthened include:

1. Supporting the development of structured assessment tools to better capture frontline needs and experiences in order to inform response.
2. Reinforcing health improvement methods and collaborative approaches to deliver aims and objectives, as well as rapidly evaluate learning.
3. Commission and incorporate the use of technology to deliver aspects of the care and management pathway, but also to help support needs assessments, feedback reporting, analysis and information sharing.

These actions need to pay particular attention to vulnerable, marginalised and at-risk groups within communities and hospital settings.

The maintenance of these principles, similar to the coordination model, will need to be delivered by resource investment and capacity to support the development of technical guidance as well as the means to improve project management and evaluation. It is in recognising that regardless of the type of humanitarian crisis, with COVID-19 being no exception, the themes outlined above will need to be considered and addressed systematically as part of the national and local response. In particular, adapting the tools outlined in Sphere will support a more community and needs-focused alignment which is required to tackle the challenges highlighted earlier.

NHS Priority Challenge 3: Health Workforce

Certain key specialties at the forefront of the response have been significantly and chronically under-resourced even prior to the COVID-19 crises, namely Accident and Emergency (in terms of both doctors and nurses) and General Practice. The nursing shortages in particular have a critical impact on care provision of intensive care patients which normally operate on a standard 1:1 nurse to patient ratio. The result has been massive redeployment of staff from other areas to try and provide aspects of care for frontline services. However, such redeployment does not always take into account existing skills of such staff, the level of training and supervision required, issues of working patterns or remuneration, or indeed how workforce could be shared across the regional health system as oppose to remaining at a single site. A core aspect of any outbreak response staff is the resourcing of Infection Prevention and Control, as well as appropriate teams to support high-quality and dignified care.

Key workforce challenges have included:

- Senior specialist staff (e.g. consultant cardiologists or rheumatologists) being deployed to support writing of patient discharge documentation or undertake simple procedures such as drawing blood samples, when they would be better utilised providing telemedicine consultations for high risk patients in the community, or for patient reviews in hospital settings.

- Junior nursing and medical staff feeling unsupported with heightened levels of anxiety due to the complexities of offering care in units that are not their own, and not having had enough induction to support their work
- An initiative to deploy Diving Medical Technicians who are familiar with managing oxygen delivery and working in high stress environments, to support critical care services, was unsuccessful because due to NHS human resource policies on employment salary scales

Applied Humanitarian Learning Recommendation 3

Led by the World Health Organisation, Emergency Medical Teams (EMTs), comprising health professionals and critical support staff (such as an orthopaedic surgeon, anaesthetist, nurses and logistician), have long been utilised during the international response to humanitarian crises. More recently, the humanitarian sector has recognised the importance of ensuring a classification and minimum standards of such teams, as well as ensuring a certification and registry of such teams to allow for the right skills to be deployed for the required need, and who are trained for the ecosystem in which they are operating. The UK itself is one of the few countries with a certified EMT for the deployment in humanitarian disasters[3].

The concepts and learning in the development of the global EMT initiative have direct relevance to the workforce challenges we currently face in the NHS, where staff from a range of other departments and services are being asked to work in different, unfamiliar environments, with the expectation of delivering clinical and nursing care whilst maintaining personal physical and mental wellbeing.

The current UK COVID-19 response does not provide clear recommendations on the way hospital and community teams can be comprised of a multi-disciplinary workforce matched on skillsets and focused on task-shifting and patient care requirement. There is a need for cross-agency recommendations on team members and competencies, based on the level of care setting (e.g. General practice, A&E, Medical Ward, Intensive Care), as well as guidance on terms, skills and certification.

There is scope for multi-disciplinary teams to support a number of roles such as:

- Basic critical care skills
- Basic critical care nursing skills
- Foundation skills in ward-based care
- Foundation skills in emergency care
- In-hospital dignified and palliative care
- Community-outreach support for dignified and palliative care
- Infection prevention control and PPE management

Closing remarks

[3] https://www.uk-med.org

Whilst we appreciate that the UK has an established system for the management of the COVID-19 response, it is clear that this will need to evolve significantly throughout the course of this pandemic.

We highlight the emerging challenges that the current incident management approach brings to staff on the frontline, and related insights taken from international humanitarian response experience. Building upon this we propose some recommendations that can adopted to enable the response to be better coordinated at multiple levels and to continue to be increasing driven by the needs of communities and frontline healthcare workers.

We would welcome further dialogue on this matter.

Thank you

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