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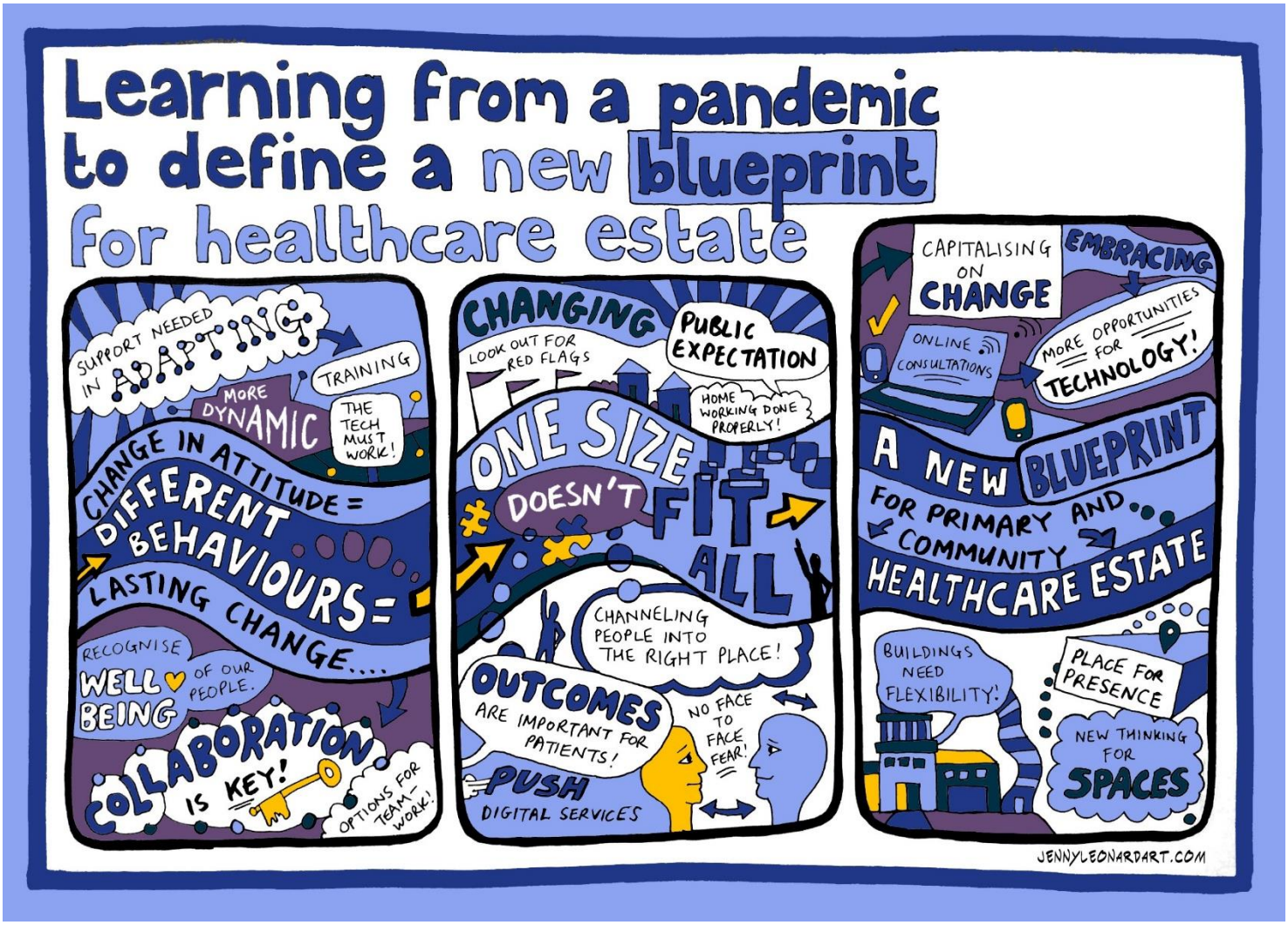


**When the Covid-19 virus took the country by storm in mid-March, it is fair to say that no one was ready for what was to unfold.** Over the past few months, we've been supporting clients respond to business-critical issues that have arisen as a result of this pandemic and we have seen a lot of change.

So, on the 24 May 2020, almost 100 days since the country was placed into lockdown, we invited a number of our healthcare clients to a virtual round table event to reflect on their recent experiences, discuss the challenges they have faced. We also explored the opportunities that lay ahead for their organisations and the sector at large.

This short report summarises the discussions at that event. If these somehow echo your own experiences of the past few weeks and your aspirations for the future, we invite you to join the conversation on LinkedIn.

# Introduction

A number of reports in the media have described Covid-19 as a black swan event. But is it, really?

The triple test for a black swan event is that it is an unforeseen event, that carries an extreme impact, and is retrospectively predictable.

No one would question the severity of the impact that this pandemic has had, but whether the event was a genuine surprise and only predictable retrospectively is another matter.

After all, health experts have cautioned about the probability and risk of pandemics for years, and Hollywood has profited from the idea through countless movies!

A number of interesting themes were raised, but three considerations that seemed to resonate the most were:

1. changing attitude…to change;
2. one site doesn't fit all;
3. a new blueprint for primary and community healthcare estate.

The one over-riding message that we have heard from these discussions is that we cannot afford to ignore the lessons brought to us by Covid-19.

We need to use these shared experiences and changes in attitudes - and behaviours - to help shape a new vision and a blueprint for primary and community healthcare estate.

We hope that this report will provide a useful platform from which we will continue discussions and work together to develop these ideas and build solutions for the future.

**Join the conversation on LinkedIn:**
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SUPPORT NEEDED IN ADAPTING
TRAINING
MORE DYNAMIC
THE TECH MUST WORK!
CHANGE IN ATTITUDE = DIFFERENT BEHAVIOURS = LASTING CHANGE....
RECOGNISE
WELL BEING
OF OUR PEOPLE.
COLLABORATION IS KEY!
OPTIONS FOR TEAM-WORK!

# Changing attitude…to change

**With Covid-19, we have seen that given the right stimulus, people can and do, react well to change and mobilise quickly. But have we have seen a change in attitudes that will in the long term, drive different behaviours and deliver lasting change?**

Simon Taylor, Head of Portfolio Optimisation, NHS Property Services noted *"a real change in ways of working … across the NHS that happened almost instantaneously in response to Covid-19 "* The key driving force behind this seems to be the impact that the crisis had on changing people's behaviour, described by Simon as a sense of 'forward momentum' that resulted in a "*knocking down of organisational barriers and working together to tackle problems quickly*".

This change in behaviours and forward momentum does not seem to have been limited to colleagues working on the front line.

Mike Simpson, Associate Director, Northern Lincolnshire & Goole NHS Foundation Trust, noted that "*The majority of our finance, comms and supporting corporate services teams are working from home, even the Trust Board is being ran through Go To [and] its working relatively well*".

Working from home is not a new thing that has resulted from Covid-19. However, the necessity of working remotely that was brought about by Covid-19 has uprooted previously held reservations (and perhaps even biases), that staff working off-site cannot be trusted to work as productively as they would in the office. The impact of this change in attitude, and behaviour, could be huge.

Besides the obvious reduction in the cost of operating back office and support services, it brings "*some challenging debates up as to what we can be doing with offices, whether or not we increase our clinical footprint or put those buildings into alternative use. There is also ample opportunity for individuals to use some of the offices as satellites and their home and the system as a base, thereby reversing how we have always worked.*" (Mike Simpson)

A further interesting observation is the change in attitudes and behaviours in patients.

Dave Barclay, Non-Clinical Managing Partner, Living Well Partnership, noted that "*patients' acceptance that they can't see us [face-to-face]*" has considerably driven the demand for, and use of, e-consultations."

Once again, remote, technology-based consultations is not a new thing resulting from Covid-19. However, the inability to for clinicians to see patients in person has encouraged patients to step up their use of technology.

Dave felt that this change in attitude and behaviour has created a *"huge period of grace"* wherein practices can step up their technology based response processes to 'root' this new demand and way of working well beyond the end of this pandemic.

This was considered fundamental because *"there's got to be something in it for patients to encourage changes in behaviour"*.

Likewise, though, is a commitment to provide the type of support needed by clinicians to maintain the changes in how services are delivered.


**The consensus at the roundtable was that this means:**

1. properly functioning technology, that works right, first time, every time;
2. the ability of clinicians to still access the support of other colleagues for a dialogue;
3. peer learning around remote consultations and red flags of what to look out for.

**These changes, as well as the provision of strong leadership and a new trusting relationship between employer and employee, have the potential to avoid a return to 'type' and to maintain that forward momentum that can make change "stick" over time".**


CHANGING
LOOK OUT FOR RED FLAGS
PUBLIC EXPECTATION
HOME WORKING DONE PROPERLY!
ONE SIZE DOESN'T FIT ALL
CHANNELING PEOPLE INTO THE RIGHT PLACE!
OUTCOMES ARE IMPORTANT FOR PATIENTS!
NO FACE TO FACE FEAR!
PUSH DIGITAL SERVICES

# One size doesn't fit all

**Lasting change does not however mean 'one size fits all'. How services are organised and delivered must continue to be informed by the demographics and profile of the population they are serving, the size of GP practices, available resources, and the appetite / capabilities of those accessing the services.**

Lisa Medway, NHS South Eastern Hampshire CCG, noted that "*whilst clinicians enjoy the remote consultation process, there is a concern about not eyeballing the patient and we are seeing people being brought back into their own surgeries*".

This is not necessarily a return to 'type' but a recognition that the increased use of telephone and e-consult appointments, while positive in terms of improving accessibility and productivity, is not necessarily the panacea, and there will always be a clinical or social requirement for face to face appointments.

This observation led to a discussion on the requirement to differentiate between distinct types of contact and the different needs that these raise for both patients and clinicians.

Four main types of contact were identified:

1. clinical services that require face to face contact;
2. clinical services that can be done remotely – online, video, phone etc;
3. non-clinical services that cannot be done remotely (such as, reception services in buildings open to the public); and
4. non-clinical services that can be done remotely (such as, back office support services).

It was also noted that a differentiation in the type of remote working is also required. While the most obvious form of this is home working, it is not always the most appropriate. For example, clinicians providing patient consultations from home may not be appropriate if privacy cannot be assured.

Likewise, however, it was noted that "*clinicians don't need to be in a clinical space to provide remote consultations; they need a space where they can hear and see patients clearly and the technology works*". That could mean a rented space in an office block, or a former retail space converted for that purpose, or some shared 'hub' in the community.

**But are providers ready for these changes?**

Dave Barclay believes there may be "*a difference by clinician. With HCA's and Nurses, face-to-face delivery is what they do; for example, giving injections and doing wound dressings. Some of the more Senior Nurses are really happy doing diabetes and asthma reviews over the phone, and we've possibly seen more of a take-up because of that. [In contrast] Advance Nurse Practitioners, who are doing Urgent care, have found the change really difficult.*"

Differentiating between the nature of different clinical services is therefore at least as important as distinguishing between clinical and non-clinical activity. As such, some of the more general assumptions of the ease of remote and technology based working applicable to many services in other sectors may not be so readily transferable to the healthcare arena.

More discussion must therefore ensue to 'map out' different alternatives for different types of services, patient demographics, and clinician needs, so that interactions between people can be channelled in the most productive way.


CAPITALISING ON CHANGE
EMBRACING
ONLINE CONSULTATIONS
MORE OPPORTUNITIES FOR TECHNOLOGY!
A NEW BLUEPRINT
FOR PRIMARY AND COMMUNITY
HEALTHCARE ESTATE
BUILDINGS NEED FLEXIBILITY!
PLACE FOR PRESENCE
NEW THINKING FOR SPACES
JENNYLEONARDART.COM

# A new blueprint for primary and community healthcare estate

**An obvious starting point for these discussions would be to supercharge past and on-going discussions on how existing estate can be reconfigured and/or rationalised to make way for these changing needs and demands.**

But Covid-19 may have provided an opportunity to push the boundaries of these discussions much further and encourage a more radical approach. Instead of looking at how space can be used in a different, more flexible way so that healthcare professionals can work more productively, there should perhaps be a greater focus on understanding how professionals can access patients differently, and work differently, and the impact this could have on the type, nature and number of buildings required.

For example, clinicians don't always need a clinical space, but they do need an appropriate space for consultations – spaces that are free from distractions and where patient confidentiality can be maintained.

Depending on the clinical services in question, "*there is no reason why some place-based, face-to-face care couldn't [for example] be delivered through a shop instead of a traditional GP surgery. All we need is a presence to see patients in a locality that is convenient to them.*" *(Dave Barclay)* Similarly, support staff also need appropriate spaces to work from, and in many cases, old buildings that house so many current GP practices are not designed to offer the flexibility required for handling present, let alone, future workforce models.

The inherent structural inflexibility of some of the existing and older buildings through which services are provided is a major stumbling block for change. These buildings must be recognised and addressed with urgency, as should the policies and directives that regulate their use.

As noted by Phil Aubrey-Harris, Associate Director of Primary Care, NHS Southampton CCG, the changes in perception, attitudes and behaviour brought about by Covid-19 is "*an opportunity to seize the day, embrace technology and get rid of old, not fit for purpose buildings*". It is also an opportunity to accept that "*the last set of health building notes is the blueprint for primary care estate published (I think) in 2013 and is painfully out of date - it still says for every 10,000 patients you need xx amount of consulting rooms, which you just don't need anymore... "*

Likewise, Mike Simpson felt that "*as an Acute Trust we have a limited estate envelope and the requirements of social distancing and delivering clinical services on the front-line is becoming a challenge for us. There's never been more of a need for the community and the primary care networks to support the prevention agenda, so that patients that can be treated within the primary and community network, closer to home, rather than turning up at hospital.*"

Stricter infection control and social distancing measures brought about by Covid-19 are likely to be with us for a long time and require permanent solutions for different patient flows and space arrangements. This challenge could be an incentive to finally move many of the services currently based on hospital sites to either a digital platform or to local primary and community estate.

This was echoed by Simon Taylor, who observed that *"in some cases, primary care is at full capacity and we have no option but to move or expand a building…but if we can move out non-essential elements, that is potentially a neat quick fix."*

While there is an important role for space utilisation and building configuration solutions, a more effective solution for the long-term needs of the entire health estate seems to be centred on a new and comprehensive blueprint for the primary and community estate.

Furthermore, this blueprint should not only address the physical requirements of the services to be delivered, but also the human dimensions of the practicalities that such changes would bring to clinicians, support staff and patients alike – issues such as informal peer support and collaboration, loneliness, safety and employee wellbeing.

# Conclusion

**So where does this leave us? And what are the next steps?**

We are currently drawing on all of this experience to develop a structured strategy and methodology for Covid-19 response going forward. Called *'Building in Resilience'*, it identifies the key issues that need to be addressed both in existing buildings and future ones for which business cases are currently being written.

The government's 'New Deal' announced at the end of June puts jobs and infrastructure at the heart of its economic growth strategy - with a big element of the deal focused on healthcare. But to make the most of the 'New Deal' and the learning opportunity that the virus has brought us, we need to continue to work together.

We think it is crucial that NHS organisations assess their facilities systematically and develop SMART plans for adaptation and emergency response. *'Building in Resilience'* will guide estate managers and commissioners through the process, helping to produce robust future-proof estate strategies.

If you'd like to receive a copy of *'Building in Resilience'* please contact us via email: enquiries@gbpartnerships.co.uk.

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