# COVID PROTECT

## A Digitally-Enabled Service to Support Vulnerable Patients

## Roadmap for Adoption

FEBRUARY 2021

**Covid Protect:**

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*Roadmap for Adoption*

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# ACRONYMS

| | |
|---|---|
| CCG | Clinical Commissioning Group |
| COPI | Control of Patient Information |
| COVID PROTECT | **C**entrally **O**ptimising **V**ulnerable **I**ndividuals through **D**ata; **P**rotect **R**isk **O**ptimisation **T**hrough **E**clipse **C**linical **T**riage |
| CSU | Commissioning Support Unit |
| CMO | Chief Medical Officer |
| GP | General Practitioners |
| GPP | General Practitioner Practices |
| PCN | Primary Care Network |
| PMO | Project Management Office |
| PSL | Prescribing Services Limited |
| SOP | Standard Operating Procedures |
| SPL | Shielded Patient List |
| STP | Sustainability and Transformation Partnership |
| VCT | Virtual Clinical Team |
| VST | Virtual Support Team |

# OVERVIEW OF THE ROADMAP

# CONTEXT AND RATIONALE

*Covid Protect* is a real-world example of a project that used digital innovation to drive system transformation during a crisis. Lessons learned about design and implementation of the project are likely to be valuable for future efforts to move digital innovations further, faster. Importantly, solutions to shared problems that are developed organically from the field are more likely to be taken up by peers and sustained over time. This Roadmap is intended to be a practical resource for executive and operational staff in health and social care, including clinicians, digital technology leads, and others, seeking prototypes that could be replicated rapidly across the United Kingdom.

## 🔍 What was Covid Protect?

*Covid Protect* aimed to proactively support people identified as highly vulnerable to COVID-19. In addition to the national Shielded Patient List, an additional 12,000 people were referred to health and social care services.

## A.  Context of the *Covid Protect* project

Despite increasing evidence that social care is central to good health, efforts to integrate health and social care services have struggled to overcome long-standing silos. As COVID-19 hit the UK in February 2020, the NHS generated a Shielded Patient List, tasking local authorities with contacting extremely clinically vulnerable people to offer help, social care, and support, working in coordination with other relevant organisations in the area.[1] Although the envisioned level of patient-focused linkages across health and social care was unprecedented, the COVID-19 global pandemic upended every aspect of society, forcing fundamental changes to the way we think about protecting the health and well-being of those most vulnerable among us and sparking digital innovations across the UK. In Norfolk and Waveney, a team of highly diverse organisations came together to create a novel innovation, capitalizing on existing digital technology to support better coordination across health and social care in responding to needs of vulnerable people. *Covid Protect* aimed to proactively identify those individuals most at risk of severe illness from COVID-19, shield these individuals and minimize the risk of hospitalization and mortality. The project escalated health and social care needs for response by clinical and non-clinical teams, without compromising the safety of emergency practitioners or overwhelming ambulance services, accident & emergency services and clinical resources in the region.

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[1] See "Shielded patients list: guidance for local authorities"

## B.     Purpose of this Roadmap

Our team was interested in understanding the design and implementation of *Covid Protect* for several reasons. First, the project is an example of a digital technology innovation that was implemented extraordinarily rapidly during a global pandemic. Second, the approach demonstrated capacity to engage community members who are traditionally hard to reach, generating insights important for the health equity agendas in both the US and UK. Third, the National Shielding response to COVID-19 required linkages across health and social care for patients, an area of great interest in both the US and UK; we were interested to see how *Covid Protect* managed to accomplish these connections. Fourth, the effort established an infrastructure that will be used for a range of other population health management purposes, including fall prevention, cervical cancer screening and better support of patients with diabetes. Finally, *Covid Protect* may have benefitted patient outcomes including rates of hospitalization, COVID-19 virus infections and mortality, as suggested by preliminary findings from the CCG Research group (appendix H).

This Roadmap, grounded in the experiences of the *Covid Protect* team, highlights key processes, practices and tools related to the design and implementation of the project. We carried out a rapid case study, synthesizing archival documents (e.g., policies, protocols, interagency communications), and information gathered from interviews with 26 key informants most closely involved with the project (see appendix A for more detail on study methods). The Roadmap first describes a high level overview of the essential building blocks of the project: the operational model and the governance model. The Roadmap then turns to the role of leadership and management in project design and implementation, offering insights into key 'ways of working' in the project. The following section reports how project leadership managed three core tensions: balancing central control and local adaptation, promoting both risk taking and accountability, and working across diverse organisations as both a strength and liability. The Roadmap closes with a brief summary of next steps in the evolution of *Covid Protect*.

# DESCRIPTION OF *COVID PROTECT*

## A.    The operational model

In response to the outbreak of COVID-19 in the UK in February 2020, NHS Digital generated a Shielded Patient List (SPL), tasking local authorities and primary care with contacting extremely clinically vulnerable people to offer help, social care and support, working in coordination with other relevant organisations in the area. As shielding went into effect on 23 March, individuals on the SPL were eligible for the national support offer, which provided food and medication delivery, priority access to supermarket delivery slots and additional support from NHS Volunteer Responders after registering via a national website or dedicated government helpline.[2] In addition to the national support, shielded individuals living in Norfolk and Waveney had access to the locally developed *Covid Protect* scheme, a local approach that built on national

### Operational Model in a Nutshell

- The operating model brought together multiple diverse organisations to respond to a variety of patient needs. While this came with challenges, it meant that the project could respond to a wide range of patient needs effectively, including time-sensitive COVID-19 concerns.

- Given the large number of people and organisations involved, a Central Team group was needed to drive the project forward. In the early stages this required a significant time commitment from members, and therefore buy-in needed to be particularly high. Ensuring people with authority to take decisions were part of the group and were able to express divergent views was important.

- Allowing local flexibility in responding to alerts enabled localities to make the most of resources available to them and provided a sense of local ownership over the project.

- Putting together a virtual support team to telephone patients that had not responded to the online questionnaire ensured that patients without digital access were not excluded and that health inequalities were not widened.

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[2] See "Guidance on shielding and protecting people who are clinically extremely vulnerable from COVID-19"

efforts. The scheme was also available to a set of individuals not on the SPL, but who were identified by General Practitioners (GPs) and the Eclipse electronic patient record/practice management software tool (appendix G) as vulnerable. Eclipse was both used as a safety net to check patients who were initially missed and ensure they got the national letter, as well as to identify a wider cohort.

> *"There were people who got a national letter, and Covid Protect was able to come up with a risk score to identify [additional] people that would be at risk because of the information that was on the NHS Pathway system…A proper lockdown meant people were told that they had to shield and be at home for 12 weeks. It became, 'What can we do to support this vulnerable group?' We needed to put in place a support structure for them during this period."*

*Covid Protect* was designed to provide daily 'one stop' screening of shielded patients and rapidly triage them across a comprehensive safety net of health and social care resources as needed. This effort required intricate coordination across a number of different organizations in 4 out of 5 localities in Norfolk and Waveney: North Norfolk, West Norfolk, Great Yarmouth and Waveney (East) and Norwich.
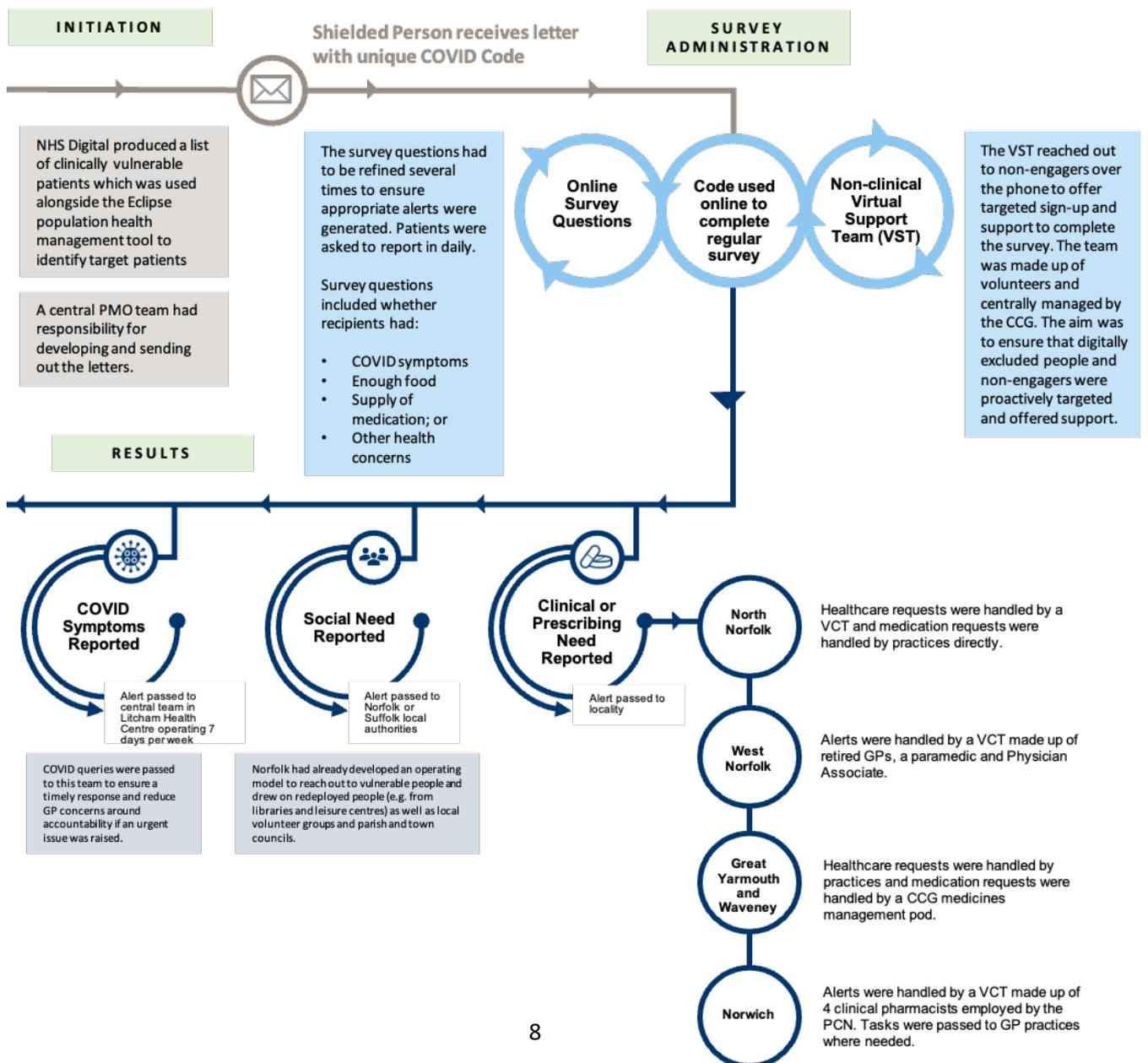
### Step #1: An expanded list of targeted patients is generated.

The Chief Medical Officer (CMO) for England, along with the CMOs of the devolved administrations and other senior clinicians, commissioned NHS Digital to produce a list of extremely vulnerable people at "high risk" of complications from COVID-19, who should shield for at least 12 weeks (called the "shielded patient list, or SPL).[3] In the initial stages, as part of the *Covid Protect* offer, the developers of Eclipse identified patients who had not received a government letter but should have, asked practices to check that list, and then sent the letter on behalf of the practice. *Covid Protect* also used the SPL alongside the Eclipse electronic patient record/practice management software tool (appendix G) to clean national lists and identify a wider group of those who were clinically vulnerable/moderate risk.[4] The project initially (early April) set out to reach 28,513 people who were clinically vulnerable to COVID-19, 19,000 of whom were on the SPL. With the identification of additional individuals through the SPL and Eclipse data, this number increased to 42,000 people who were clinically vulnerable to COVID-19, 30,101 of whom were on the SPL. Essentially, the expanded list captured nearly 33% more at-risk individuals than the SPL.

Project leadership were nimble in adjusting the scope in response to several factors: 1) the project was rolling out at pace, and leadership were trying to coordinate with national efforts in real time; 2) leadership reacted to emerging evidence, such as people in more deprived areas having poorer outcomes from COVID-19, pivoting to focus on deprivation; and 3) the team needed to operate with available resources. Initially the team planned to provide clinical input and decisions about hospital admission; however, they identified the pressing unmet need to enable patients to shield by supporting their needs and optimising their care. In prioritising efforts, the team had a choice whether to call everyone once or to assume those that had gone online once could return to it if they wished to, thereby allowing repeat calls to those most in need.

> *"One of the first key aspects was to…accept that at times the scope needs to change, and be able to change it pretty quickly when needed. The initial scope of the project was 'Here's a tool that we can use to risk stratify people who are clinically vulnerable to COVID-19 and provide a centralized way to give them the ability to provide regular updates, and where alerts were generated from that feedback, to provide support for those people'…then we decided to focus in on deprivation…where patient updates generated alerts, genuine clinical queries would pass down to the practice side directly or through a virtual clinical team. If it was social-related, it would go directly to Norfolk or Suffolk County Council. If it was a COVID symptom query it would go to that central team."*

> *"Patients were all sent letters… as the project went on, it became apparent there was quite a lot of people…that weren't able to access the online thing. Then we tried to prioritise people that didn't have access to the online platform. Then as the project went on further, we honed it to people that were at greater risk that were living in areas of greater deprivation. Because it became a bigger thing than anyone imagined, we had to really hone it in."*

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[3] For more information on the shielded patient list and how it was developed, see "COVID-19 – high risk shielded patient list identification methodology: Background"

[4] See "Shielded patients list"

As the project progressed, the team also linked datasets to the national Index of Multiple Deprivation with the aim of prioritising those who may be particularly vulnerable living in deprived areas.[5] Of the population supported by *Covid Protect*, 49.8% were of the top 30% Deprived Population as determined by national metrics. The team recognized that the people with most deprivation who were at greatest risk of becoming unwell were also less likely to be digitally able or inclined to engage. Therefore, they targeted people who had not engaged previously and prioritised those in the higher deprivation index areas and in-reached by prioritising them for calls.

### Step #2: Each targeted patient receives a letter and completes a questionnaire.

At the national level, the Department of Health and Social Care and Ministry of Housing, Communities and Local Government sent patients on the SPL a series of letters outlining the shielding policy, guidance for staying safe and available resources.[6,7] The *Covid Protect* team sent letters to both those on the SPL and the expanded group (patients deemed to be vulnerable to COVID-19 as identified by *Covid Protect*). The letter (appendix B) asked patients to register and provide daily updates via the *Covid Protect* system, using a unique code linking a website with an online questionnaire (appendix C). The questionnaire asked recipients a range of questions including whether they had COVID-19 symptoms, whether they had enough food and medication and whether they had any other health or social concerns.

### Step #3 The virtual support team supports patients as needed.

Where patients did not engage with the online questionnaire, they were contacted by phone by *Covid Protect's* central non-clinical virtual support team (VST) to complete the questionnaire verbally. This team was made up of 80-100 volunteers who worked remotely from their homes, four supervisors and an overall manager employed by the Clinical Commissioning Group (CCG). Volunteers came from the CCG, the Commissioning Support Unit (CSU), Norfolk and Norwich University Hospital (an acute trust), James Paget University Hospital (an acute trust), Norfolk and Suffolk Foundation Trust (a mental health trust), West Social Prescribing team and the Red Cross. Volunteers completed over 1250 shifts and almost 4000 hours between the launch and August 1, when the project paused. A deliberate decision was taken to use volunteers to staff the VST as there was a view that they would be particularly motivated. While found to be the case, challenges with this approach included filling rotas around the volunteers' other commitments (*"that made it tricky to develop the rota, but we did manage to do it"*) and significant investment needed for training (*"none of us had ever done anything like it before…the task was to train them up, so they knew what they're doing… What script would they use? When people speak to them, how do they respond in those interactions?"*).

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[5] See "English indices of deprivation 2019"
[6] See "Guidance and updates: Highest clinical risk patients"
[7] See "Advice for people at high risk from coronavirus (shielding)"

### *Step #4: Patients are triaged by alerts.*

All questionnaires completed online and by telephone triggered alerts that were triaged to appropriate teams. Concerns about COVID-19 symptoms were passed to an in-person team at Litcham Health Centre (a primary care practice where the project's clinical lead GP was based) which operated seven days a week. Continuous coverage was made available to ensure patient safety and professional accountability if an alert could not be reviewed and acted upon
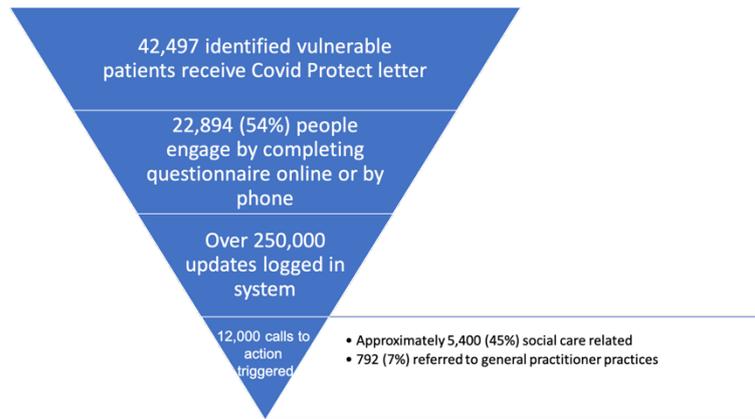


Figure 2. Patient Engagement and Generated Alerts

immediately. Social care needs were passed to local authorities. Alerts relating to a clinical or prescribing need were passed to the appropriate locality teams. By mid-June, nearly half of all the alerts generated in Norfolk and Waveney related to social needs, while only 17% related to COVID-19 surveillance. This pattern was also mirrored in each of the localities. By the 14th of July, 22,894 (54%) people engaged with the project, and had interacted over 250,000 times; of the 250,000 updates, over 12,000 triggered a call to action. Most of the calls to action (45%) were social care related (food and meds); 792 of those were passed to general practitioner practices (GPP); the rest were managed by Virtual Clinical Teams (VCT), the Central Surveillance Team, and Local Authorities.

Figure 3. *Covid Prot*ect Project Timeline
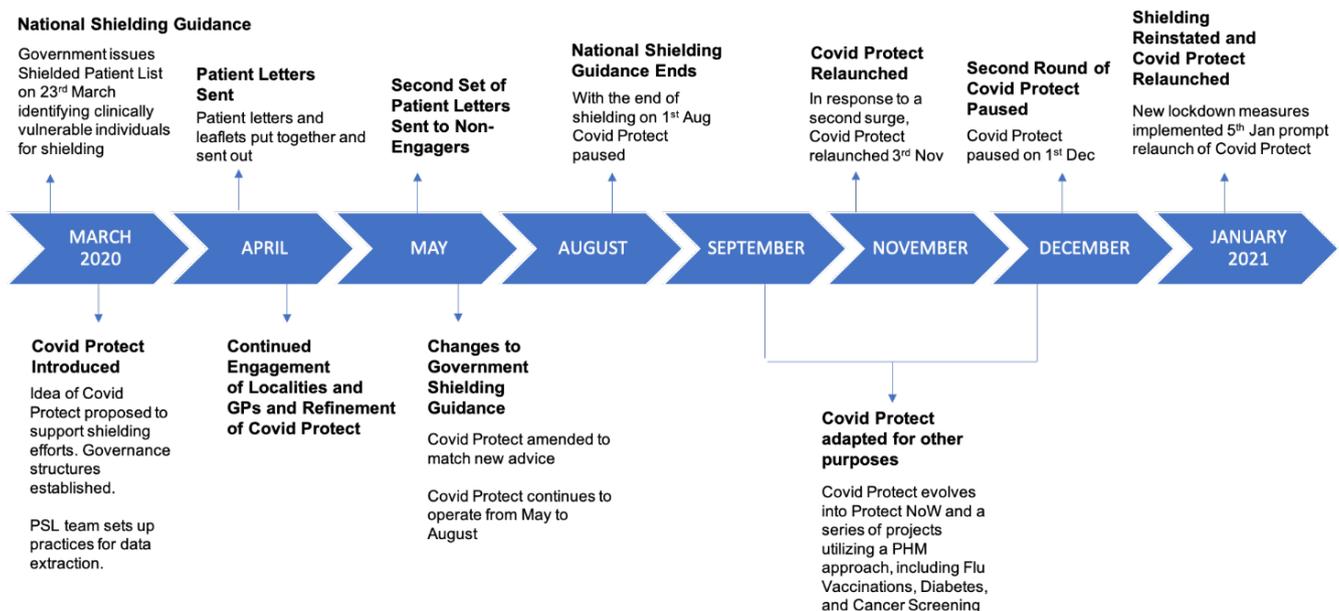
## B.    The governance model and ways of working

### Governance structures

The project governance was "*really quite robust,*" consisting of central leadership teams and additional teams within each locality. Leadership devoted attention to including representation of all key stakeholders, developing supportive and efficient meeting structures and tending to communications across the project.

### *Central leadership teams*

The central leadership team included the necessary expertise and authority to implement the project, convening frequently and regularly to support coordination among the many components. The project was led by an Executive Lead based at the CCG, with the support of a clinical lead, a GP based in Litcham Health Centre, West Norfolk, who developed Eclipse (appendix G). The CCG dedicated staff to the project from an established team to create a central project management office (PMO). The Executive Lead assembled a Central Team (also called the "Project Group") which included: a clinical GP lead from each locality, representatives from GP membership organisations, the VST lead, members of the PMO, the CCG chair and other CCG staff, and representatives from the East of England Ambulance Service NHS Trust. The CCG also developed a central non-clinical VST staffed by volunteers.

### *Locality teams*

Teams were also developed by each respective locality; membership and responsibilities varied according to patient/community needs and available resources. In West Norfolk, all healthcare and medication requests were handled directly by the locality team, which was made up of retired GPs, a paramedic and a Physician Associate. Similarly, in Norwich, the locality team handled all healthcare and medication requests in the first instance, only passing tasks to practices if required. In Norwich, the team was made up of four clinical pharmacists employed by the Primary Care Network (PCN). In Great Yarmouth and Waveney, healthcare requests were handled by practices while medication requests were sent to a CCG medicines management pod. In North Norfolk, healthcare requests were handled by the locality team and medication requests were handled by practices. The Standard Operating Procedure (SOP) developed in North Norfolk (appendix F) highlights the detailed considerations that localities took into account when developing their models. For example, it drew on ethics guidance from the British Medical Association, and set out procedures for when escalation from the VCT would compromise the GP's ability to manage workflows and how to assist GP practice in care homes. The project team included a liaison that coordinated across localities and from the Central Team out into communities.

## Ways of working

### Ways of Working

- Gain explicit, visible endorsement of the project from senior executives
- Engage all stakeholders through a multi-pronged engagement strategy
- Ensure every member of staff feels valued
- Cultivate a psychologically safe culture for innovation to flourish, supporting continuous improvement that does not look to ascribe blame
- Actively and continuously empower middle management and the front line

### *Gain explicit, visible endorsement of the project from senior leadership*

The Chief Executive of the Norfolk and Waveney CCG, as well as her leadership team, provided steady, explicit support from the conceptualization of the project through to implementation. This support was valuable to the project team in both recruiting partners and in managing up to the NHSE strategic level. Even as national guidance was being developed, regions were confronted with the need to make rapid decisions with incomplete or constantly changing information, whilst motivated by a strong sense of urgency. Visible support of senior leadership was also key to creating a common mission (*"there was a shared imperative and a very clear, shared objective as to what we were doing"*). The messaging was effective in bringing the broader system onboard and aligning efforts across a wide range of stakeholders, both internal and external to the project:

> *"Very early on, our Sustainability and Transformation Partnership leader and our chief exec made a firm commitment to the project. That was very powerful…within our CCG. There were quite a few external commitments made, both to NHS England and to our wider partners, so that we were working in collaboration with the County Council and district councils…and that message was very clearly portrayed externally in the communications that [name] had across the STP partnership."*

At multiple junctures, the commitment of senior leadership in prioritising the project was demonstrated to members of the *Covid Protect* team, who *"heard directly from seniority that they could get on with things"*. Team members felt they *"could raise issues immediately and they were unblocked"*, for example, purchases were promptly approved and managers *"cleared the way"* by removing issues that might typically arise. When the project was put on pause with the temporary abatement of the pandemic in August, the full team membership received an email from senior leadership, again acknowledging the value of their work (*"…you should all be very proud of what you have done, and I shall continue to support you"*).

*Engage stakeholders through a multi-pronged strategy*

Address concerns: The extraordinary breadth of stakeholders connected to the project (GPs, patients, local county and district councils, CCGs, volunteer organizations, clinicians and volunteers from a range of healthcare organizations) required significant attention to engagement throughout the development and implementation of *Covid Protect*. In the early stages of the project, various stakeholders expressed a lack of clarity around how *Covid Protect* aligned with the national shielding program and questioned the added value of the project. Some worried that participating had the potential to generate demand for care that would outstrip capacity. Others expressed concerns about data privacy (*"data was a huge challenge and how we share it…typically that stops partnerships working"*), which lessoned over time (*"As time's gone on, I think the practices have become a lot more confident with the use of the data. There's the legal side of data sharing, but there's also the trust side"*).

**Implementation Tip**

**Balancing continued engagement with being able to respond promptly and appropriately to all interactions can be difficult. While asking for daily updates can be appealing to ensure continued buy-in, responding to those updates can be hard to manage where large numbers of patients are engaged.**

Solicit input: The project team had several members whose primary responsibility was to serve as a boundary spanner with the GP practices (*"it was very much about working in collaboration"*). Clinicians were actively encouraged to provide input into design (*"the project…brought clinicians in right at the beginning and every decision was clinically driven and clinically justified…clinical backing was absolutely key"*). In addition to the active solicitation of input, project members described extraordinarily rapid responsiveness to feedback. For instance, the software programming was viewed as *"a heroic effort"* as suggestions were implemented within days (*"people could see how fast their vision was being fulfilled…it gave people a belief that they could trek on and actually achieve what they set out to achieve"*). A sense of common purpose meant that problems were not seen as insurmountable:

> *"We were meeting every day, and we would look at what was proposed and say well, that could be changed or have you thought about linking in with such and such. They would go off and changes would be made…If people said, that's not going to work, it was well, how can we get 'round this….it was very much developed as a response each day, altered, whatever was felt to be needed."*

Engage patients: Patient engagement was an important feature of *Covid Protect,* with several ways to capture the patient inputs into the process. For example, call centre staff shared patient experiences and suggestions from their phone conversations within their team meetings. At the pause of the project, a feedback survey was completed, aimed at learning whether people participated and understanding their overall experiences. A total of 252 surveys were completed. Among patients completing the feedback survey, 230/247 (93%) responded to the question on engaging in *Covid Protect*. Among people who were engaged, the vast majority found the service helpful and the support reassuring. For those who did not participate (17%), some felt they had been incorrectly identified as high risk. Some people identified technical issues that had prevented them from completing the questionnaire, as well as gaps in follow-up communication. Others had no need for the service but found it *"very reassuring to know the service was there"*.

Meet intentionally: Project meetings were designed with careful attention towards attendees, agenda setting and making efficient use of the collective time. In the early stages of the project, the Central Team met virtually daily at 5pm, demonstrating the commitment of the project members and enabling the project to progress effectively at pace. The Central Team comprised diverse stakeholders with the expertise and authority to take decisions on behalf of the project and their locality. The executive lead put together the agendas, which included updates on progress and activity, as well as the focus for the week ahead. Where important decisions needed to be made, systematic tools such as options appraisals were used, creating standard processes for informed and transparent decision-making.

Tend to communications: Frequent, sustained, open and flexible communication was prioritised. A decision was taken to engage primary care through the systems already set up to communicate about COVID-19, wherever possible. Participating practices received communication from the Central Team via letter on how the project was progressing, the letters vulnerable patients had received, what general practice should do with patients on the SPL, and the *Covid Protect* process (including the alerts they needed to action, if any). However, where feasible, communications were embedded in existing channels and forums (*"we were meeting regularly anyway, so this was just one other thing on the agenda"*). In addition to communications from the central PMO, localities developed their own communication strategies. For example, the GP membership organisation North Norfolk Primary Care primarily used practice manager group meetings, as well as e-mails, to keep practices informed and engaged. In Norwich, communication was primarily done via e-mail, with more substantial messages communicated via webinars. Operational teams in the localities were able to access virtual drop-in sessions to highlight problems or ask questions.

Despite these concerted efforts, the scale and pace of the project meant that keeping all practices informed and engaged was difficult (*"everything was happening so fast, trying to keep the practices in the loop on everything was very difficult"*). In some cases, practices were not fully aware of the project. Consequentially, there were examples of patients contacting their practice, and being informed that the *Covid Protect* project was a scam. In the early stages of the project, inaccuracies in the NHS SPL meant that some patients were contacted who should not have been, and others were missed. This caused difficulties for practices who received patient complaints, and some were concerned that PSL's data was wrong. These issues meant that the CCG and, in some cases, clinical leads responded to practice concerns on an ad-hoc basis. Significant time and attention was given to engaging practices; nevertheless, given the scale and pace of the project, there was room for stronger communication to support decision making and information flow from the national to local levels.

### *Ensure every member of staff feels valued*

The *Covid Protect* team comprised members who volunteered their time, or managed multiple roles and competing demands, even while handling their own personal challenges amidst the pandemic. The project's executive lead invested substantial attention to the relational aspects of the work to ensure team members were valued, and authentically involved in the effort. For example, key stakeholders on the project were given role titles (*"…you felt really proud"*)*. Clinical representatives from each of the localities were known as 'clinical leads'. Titles also helped to support role clarity, maximizing the ability to leverage complementary skills within the highly diverse team of clinicians, operations leads and volunteers.

**Implementation Tip**

**Those in leadership roles should ensure that all project members are valued, and that everyone has a voice to challenge the group and express their opinion. Effective leadership should happen at every level, from senior organisational leaders to operational leaders managing teams on the ground.**

Expressions of appreciation for team members were creative and took many forms; for instance, *"whenever there was a good feedback, where there was a good story, he would always bring it up and celebrate"*. One manager sent an upbeat or humorous email to staff each morning. When the project closed, all staff were given a mug to thank them for their involvement in the project and mark its success. A final project meeting with the VST highlighted all of the work they had done over the preceding months both quantitatively (over 1250 shifts and almost 4000 hours) and via feedback from users of the service: *"I am being so well cared for, I feel like the queen"*. The executive project lead also asked all clinical leads to thank the volunteer staff for their efforts, and to reflect on the important role they played in the project.

*Cultivate a culture for innovation to flourish, supporting continuous improvement that does not look to ascribe blame*

The leadership team cultivated a no-blame learning culture, with a shared goal of continuous improvement. Clinicians were actively encouraged to provide criticism and input into the design of the software, and the team was highly responsive to adapting the tool to meet needs of clinicians (*"initially we had a small pilot group, they were the key part of the design"*). Call handlers made notes in the system and as per the operating model, passed cases to VCTs, practices, the central Litcham team or local authorities as appropriate. This process was continually refined. For example, in one case a GP followed up with a patient after receiving a referral from the VST and the patient informed the GP that they did not have any issues. This was investigated thoroughly, including going back to the call handler and re-assessing the notes made. Eventually it was concluded that the patient had changed their response, although the no-blame culture of checking provided reassurance to all involved. Because the project was proceeding at pace, many elements were *"fluid and dynamic"*, with continuous iterations.

> *"We were on a call like [Zoom], with everybody sharing and airing all their concerns, which meant there was lots of learning as we were going along, but in a positive way so that questions were being raised and helpfully answered by practices themselves…They were the experts in the room...they could then say, how is this going to work? Can you go back and ask the project team X, Y and Z?"*

In terms of ensuring that team members were able to contribute their varied expertise to continuously improving the effort, project leadership intentionally cultivated psychological safety (that is, having everyone feel comfortable expressing divergent or critical opinions). Through prioritising broad representation and deliberate facilitation in meetings, *"it wasn't a case that the loudest voices were heard. It was the case that everybody would be heard"*.

> *"People within the Covid Protect group challenged each other. They were able to create that psychological safety that means that everyone can contribute no matter who they are and feel in that safe space to also appropriately challenge people. What they managed to do was successfully flatten the hierarchy….That worked a lot in terms of people being able to speak up and say, "I think this is a great idea. We should do it," or say, "I don't agree with that. I think we should follow a different path."*

In another example, developing the patient questionnaire was an iterative process, and a wide range of stakeholders needed to feed into the process to ensure it worked to best effect. For example, it became apparent in the early stages that too many alerts were being generated. The initial questionnaire asked if respondents had a non-productive cough, leading to some recipients with asthma and COPD to answer affirmatively. After close review by the full project team, the questionnaire was later changed to a 'new cough' to result in more appropriate alerts.

*Actively and continuously empower middle management and the front line*

Within the team, managers and frontline staff were recognized as having necessary expertise and explicitly encouraged to propose solutions. The call handlers and supervisors were described as *"definitely exercising leadership"*. Because they were the people firmly embedded in

operational issues and *"really understood the system, they saw solutions"*. For instance, one team member described contributing to standard operating procedures for alerts:

> *"I was empowered to figure out how we were going to manage alerts that came through from the Covid Protect tool and to make sure that people that lived within the boundaries of the area were fully supported for any questions and queries that they raised through that tool. I helped to write the standard operating procedure for that."*

In an effort to ensure the data collection tool would generate needed information while not being too onerous for patients, team members with patient-facing experience gave substantial input into refining the patient questionnaire through an iterative process:

> *"The questionnaire was formulated by the clinical people that were on a steering group, but then once we were actually asking the questions, and we were able to feedback, there were lots of changes made to that questionnaire…We were able to feed into it and help shape how it went as it went along. We all felt that we were involved with that, which was really good."*

While all team members were empowered, accountability was also in place. Senior team members provided oversight and support, *"allowing people to do their own thing, but also continuously checking in".* One team member described this balance:

> *"Our senior team within the Clinical Commission Group effectively gave us permission. We had both the clinical direction and the managerial direction meeting frequently. That gave the authority to get going. It meant I was empowered to get in touch with everybody, corral the team, and make arrangements."*

## C.    Benefits of *Covid Protect*

A formal outcomes evaluation was not built into *Covid Protect* at the outset, although the project appears to have conferred benefits. An early review of available data from the CCG Research Team found that engagement in the project positively influences the outcome for hospital admissions, COVID-19 infections and mortality (appendix H). *Covid Protect* elected to include highly vulnerable individuals from the start. The national list eventually grew and incorporated many of those that *Covid Protect* had already identified, thereby pre-emptively included those vulnerable people. Importantly, the team demonstrated that with a combination of data and proactive calling it is possible to target certain groups, for example those who are most deprived, and attempt to get them to engage (appendix H). The project also established that a wide group of stakeholders could come together to rapidly develop a new digitally-enabled service during very difficult circumstances. Team members reflected on program impacts from their perspectives, including better collaboration across health and social care, supporting patients holistically, and potentially reducing burden on practices:

> *"It was a good example of work and health and social care and the borough councils and the prescribing team working together. Primary care appreciate that the patients clearly valued it because there was a lot of social support that this project was able to identify that met the needs of these patients to enable [them] to have better outcomes."*

*"It was vitally important that there was a way of supporting shielded patients in a number of ways…supporting on food, supporting on medicines, supporting on health and the fourth thing, and possibly one of the most important things, is it was a point of contact. It helped reduce the sense of isolation."*

*"The project actually resulted in a lot of engagement with the other services which was good for patients…there is potential that it lessened workload for the practices because the patients could get those nonmedical needs dealt with elsewhere."*

# MANAGING TENSIONS IN IMPLEMENTATION

## A.        Balancing central control and local adaptation

A strong Central Team was essential for rapid development and refinement of the model, ensuring a coordinated interface with national guidance and making iterative adaptations to the software and reporting forms. The Central Team was also particularly important in driving the project forward and providing the capacity to handle logistics such as developing and sending letters. Without this drive and direction, it is unlikely that GP practices or membership organisations would have had the resource to develop a similar project locally (*"the CCG released some resources…that was hugely helpful because practices were under such pressure"*). The development of one central operating model (which allowed for local flexibility) avoided duplication, allowed direct linkages into local authority operating models and ensured that resources could be used effectively across the system.

**Key Takeaway**

**The balance between central coordination and local flexibility needs to be carefully struck. Allowing too much local flexibility may result in a disjointed approach, while over-centralisation can feel prescriptive and reduce responsiveness and ownership.**

At the same time, the project leadership recognized the importance of tailoring in each locality, allowing each locality to develop their own approach to responding to healthcare and medication alerts (*"[W]e never said, 'This is how you're going to handle your alerts.' What we said was, 'This is how the system works…what you need to decide is how best that will happen locally for you'"*). Each locality assessed existing clinical capacity and the appetite of GPs to deal with alerts directly (*"the fact that they allowed each area to do their own thing was really useful"*). Taking this approach meant that localities could draw on available resources within their systems and feel a degree of ownership over their involvement and the project as a whole. Local authorities quickly developed their own operating model for reaching out to vulnerable patients when the pandemic struck, which meant they already had an infrastructure to act on alerts. However, a consequence of models being developed separately and at pace meant there was some duplication. Not only were vulnerable patients contacted as part of the *Covid Protect* project, they were also contacted separately as part of the local authority approach to keeping patients safe.

*"We very much decided early that we didn't want to rely on a kind of NHSEI centralized process that we potentially didn't feel would protect our vulnerable patients as well as we thought we could. What facilitated it was bringing people together as a group in different parts of the system…Everyone was part of designing the system. The process that we all talk about with quality improvement and how we embed something was followed in terms of how we get staff, clinicians, and patients onboard."*

The various operating models in each of the localities meant that practices were involved in the project to greater or lesser extents. In North Norfolk, for example, practices handled all medication requests, whereas in West Norfolk all healthcare and medication requests were handled by the VCT. Nevertheless, practices in all participating localities needed to buy in to the project and allow their patients' data to be shared with PSL, the developers of the Eclipse tool.

## B.    Promoting both risk taking and accountability

A second tension that needed to be managed within the project was balancing risk-taking and accountability. Moving at pace and working iteratively in rapid cycles meant that decisions needed to be made at multiple levels of the hierarchy and quickly, particularly in the early days. The project operated at risk in that the approach had not been trialled previously, it was unknown how well patients would engage and planning started before the national guidance/approach was clear. Once the project commenced, leaders and project members were empowered to problem-solve, and leaders were given autonomy to take decisions and *'make the approach work'*. A sense of urgency compelled the team to move quickly, putting aside common barriers that slow decisions: *"We need to get going now. Our patients are at risk. It's for us to look after our own patients, not wait for others to tell us what to do."* And this call to action from a clinician: *"The train is about to leave the station. We need to get on the train, and we need to direct it."*

**Key Takeaway**

**Operating in a rapidly changing environment, stakeholders balanced risk-taking and accountability by discussing risks openly and candidly, putting the patient at the centre of each decision, and moving forward as a unified team.**

*"In my role where I'm accountable, I felt real pressure whether we were doing the right thing and whether we actually would be allowed to do it. We were worried, at one point, as to whether our Covid Protect would be permitted. [name] said to me, 'Just do it.' …he's very cautious normally. I just thought…I'm just going to seek forgiveness afterwards. We did go forth. Of course, it was fine, but at the time, there was a lot of nervousness about whether it was fine."*

A national policy decision mitigated the primary risk surrounding sharing of patient data. A Control of Patient Information (COPI) notice allowed confidential patient information to be shared amongst health organisations and other appropriate bodies for the purposes of protecting public health, providing healthcare services to the public and monitoring and

managing the outbreak.[8] This made it easier for patient data to be shared between all members of the *Covid Protect* team. Senior risk managers felt empowered to assess and approve requests more quickly than usual:

> *"In England, you don't get a pat on the back in the health service for being brave. Everybody wants everything signed off and to reduce the risk of anything to about zero...because of the COPI notice saying you have a duty to share, the senior information risk officers actually understood what was coming so they signed it off really quickly...It was that burning platform thing, where we don't know it's coming but let's be as prepared as we can for it...it made all the difference in the world."*

Concerns about clinical risks were expressed by GP stakeholders and addressed in the project design in terms of back up coverage by the central VCT. Sensitive to these perceived risks, the senior team ensured transparency in communications, using a detailed visual flow diagram to help reassure GPs that they were not taking risks alone:

> *"...our visuals [were] to be really transparent as to what the process was to make sure that we weren't exposing practices to any clinical risks. 'Hang on a minute, if we think you're looking after our patients, how do we know? We'll be the ones who are clinically negligent if your system doesn't work.' That sort of concern was one of the reasons why we needed the visual."*

While certain acts of risk-taking were allowed, accountability was also preserved. Reporting structures and processes were put in place for *'grip and control'*, as well as informal feedback paths *("We could also track how many had been reviewed...We were able to gently prompt. 'You're a little bit behind on some of your reviews.' Then suddenly, magically, they would start reviewing").* While those responsible for monitoring quality and performance were committed to building in accountability, they were both flexible and mindful not to overload staff with reporting requirements that would impede delivery of care and supports to patients *("we pared it right down"*):

> *"We also had to make sure that we weren't taking any clinical risks...It was the balance of getting the governance in place in something that was so very, very fast-moving. On day one, I don't think there was a lot of governance, and there was lots going on. Over a three-week period, we tipped the see-saw to a point where, I felt, 'Yes, we've got grip control. We know what we're doing. We know what we still need to do,' and the structures were in place."*

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[8] See "Control of patient information (COPI) notice"

## C. Working across diverse organizations as a strength and liability

A third major tension within project implementation was leveraging the strengths of a multi-stakeholder effort spanning health and social care across the region, while minimizing the challenges associated with working across diverse organizations. The *Covid Protect* model brought together multiple organisations – including the CCG, health providers, local authorities and volunteer groups – which meant it could draw on a diverse range of skills and experience. Working across these groups is typically challenging in terms of differing goals (*"in the past, you would have transformation on one side…and the clinicians on the other side"*) or alignment of role and responsibilities (*"normally to get things working across systems, it would take you months or years of negotiation and working out who was going to do what…that just melted away"*). However, the extraordinary circumstances of the COVID-19 pandemic imbued the team with a clear sense of urgency and collective goals.

Team leadership was highly effective in spanning these boundaries (*"we just didn't have any usual siloed thinking"*) through reinforcing a *"common and unifying cause across all parts of the public sector…breaking organizational boundaries in a way that I've not experienced in my time"*.

Nevertheless, a consequence of different organisations working together at pace meant there was some fragmentation and duplication. This was particularly highlighted by difficulties sharing data. Given that local authorities operate on a different IT system than NHS colleagues, all referrals to local authorities relied on manual data transfer which was burdensome. Some team members reflected that in hindsight, automating this process would have been beneficial. The separate IT system also meant that there was no feedback loop for local authorities to report how they had responded to each referral.

> 📢 **Key Takeaway**
>
> **A shared enemy – the COVID-19 pandemic – motivated diverse organisations to overcome the usual fragmentation. Without a global pandemic, leaders must find other ways of generating a sense of urgency and shared commitment.**

# WHAT'S NEXT?

### Reflections

Team members reflected *Covid Protect* would have benefitted from:

- Greater clarity around aims and attention to scope drift

- Proactive planning and implementation of evaluation

- Operational and design features (e.g., less intensive staffing of the call handling teams, reduced frequency of patient daily deltas)

- Greater engagement of patient and community members

- Where GPs were not directly involved in handling alerts, strengthen communications to raise their awareness of the project

- Better promotion of the project to external audiences

*Covid Protect* has evolved to be called *'Protect NoW'* in order to signal broader applications beyond COVID-19. *Protect NoW* has laid down the foundations for projects that span health and social care, creating an infrastructure that can be used to enable a proactive, population health management approach in the developing Integrated Care System (*"Covid Protect and the project around it has opened other people's eyes to the possibility"*). Now that the infrastructure has been developed and the model has been tested, the CCG is applying it to an expanding set of population health issues, targeting hard-to-reach groups who would benefit from "more personalised" engagement with healthcare services. The CCG has invested in positions for five non-clinical call handlers to ensure the sustainability of the model and reduce the need for re-deployed or volunteer staff.

> *"Gradually, it's just got more and more embedded…We describe it as business as usual…We changed the name from Covid Protect to Protect NoW to signal really that this is not just connected with Covid…The NoW stands for Norfolk and Waveney."*

## A. COVID-19 related projects

In the wake of the third COVID-19 lockdown, the team has adopted the same model as per the second lockdown, with the goal to proactively provide information, advice, guidance and, where needed, non-clinical support during the lockdown. The effort targets those aged 70 and over, living in the most deprived postcode areas (highest 30%), and people who reported they wanted/needed regular contact in the first and second lockdowns (with no access to internet).

The CCG have commissioned Norfolk Community Health and Care to provide Long Covid clinics, although there is currently very little information on how many people might have this condition or what symptoms, if any, they are having. This initiative is focused on engaging 13,500 people across Norfolk and Waveney who have had a confirmed diagnosis of COVID-19 after 12 weeks through a standardised questionnaire (online or administered via phone by *Protect NoW* call handlers). The goals are to identify the need for additional specialist interventions, such as an enhanced chronic fatigue service, link support workers, and improve the equity of offer for patients with other long term conditions to attend exercise groups.

## B. Beyond COVID-19

*Protect NoW* has broad relevance and potential for application beyond COVID-19. Other, non-COVID-19 related initiatives recently launched include: 1) fall prevention assistance targeting people who are vulnerable to a fall and on long waiting lists for a hip or knee operation; 2) improving the links between people with diabetes to services provided by the local authorities and voluntary sector targeted at the 43,000 residents in Norfolk and Waveney who have prediabetes (beginning with 10,000 who are living in higher deprivation areas); 3) cervical cancer screening outreach to reduce inequalities in screening and improve access to interventions, targeting those eligible for a cervical cancer smear test who previously missed an appointment (5,000 women by March 2021 and up to 20,000 in 2021/22); and 4) identifying unpaid carers and strengthening social supports available to them.

*Covid Protect* laid the foundations for a holistic population health management approach that can support the developing Integrated Care System in addressing health inequalities by targeting hard-to-reach groups and those most in need of support from health services, enabling early and targeted intervention. *Covid Protect* revealed and responded to significant unmet needs, particularly for social care, in the region. As the inequalities agenda in NHS/government is pursued, initiatives such as these offer potential to assist in more effective targeting of resources. Importantly, there is potential for *Protect NoW* to address system wide goals for substantive, successful cooperation and integration of health and social care with the local population and the individual's needs at the centre.

# APPENDICES: DETAILED PROJECT MATERIALS

**A.  Case study methods**

**Research aim:** We aimed to understand *how are some geographies able to make extraordinary progress in using digital health innovations to improve health of the population, particularly in times of crisis?* We sought to identify approaches and tools that may serve as practical resources for clinicians, practitioners in social care, digital technology leads, executives and others.

**Study design:** A rapid, case study approach[1] with key informant interviews[2] and relevant archival documents e.g., policies, protocols, training curricula, operational communications.

**Ethics approval:** The study was reviewed and approved by the Yale University Institutional Review Board (IRB), Protocol # 2000028439. The study was determined to be exempt under 45CFR46.104 (2)(ii), which does not require additional IRB oversight. This determination was made due to the fact that personal health information (PHI) was not being collected, interviews were coded with a study identification number in order to protect the identity of the research participant and all files are being stored on a password-protected, encrypted server provided by Yale University, accessible only to authorized study personnel.

**Data collection:** We drew upon two primary data sources, including in-depth interviews with key informants and project archival documents. Data were collected between October 13th – December 14, 2020.

*Key informant interviews*

Key informants for the study included a mix of clinicians, executives, digital/information technology leads, nominated by the Site Lead (Table 1). The Site Lead contacted potential participants by phone or email and shared an informational document summarizing the study. Individuals who agreed to participate in the study were contacted by a member of the Yale research team to schedule the interview. All interviews were conducted via Zoom using a standard discussion guide after informed consent (including stating the goals of the study) was obtained. The guide consisted of 'grand tour' questions[3] to elicit study participants' perspectives. Probes were used to generate 'thick descriptions' of their experiences, as well as to elicit both positive and negative views.[4,5] Participants were encouraged to share their experiences including their role in the implementation of *Covid Protect*.  Interviews were digitally recorded, professionally transcribed, and reviewed to ensure accuracy.

*Relevant archival documents*

In addition to the key informant interviews, we conducted a content analysis of archival documents.  The majority of these documents were provided by the Site Lead; additional materials were shared from key informants most involved as clinical leaders of the project. These included documents that were important throughout the project such as, tools, protocols and templates (e.g., clinical model overview, patient questionnaire). The documents also included external documents (e.g., policies and regulations).

**Data analysis:**  A four-person multidisciplinary team used the constant comparative method of data analysis.[6-8] The full team independently coded four transcripts, developing codes to classify data inductively, drafting an integrated code structure. We then broke into teams of two, each team coding half of the remaining transcripts. We resolved differences in coding by consensus. The final code structure was reapplied to all transcripts. We identified prominent and unifying themes across interviews. We used established techniques to ensure that data collection and analysis were systematic and verifiable.[8,9] Qualitative analyses were conducted using Atlas.ti v.8.

Table 1.

| **Participants** (n=26) | |
| --- | --- |
| *Sex* | |
| Male | 10 |
| Female | 16 |
| *Roles* | |
| Clinical Commissioning Group | 2 |
| Central Clinical Team | 7 |
| Virtual Clinical Team | 5* |
| Non-Clinical Call Handler Team | 4** |
| Central Project Support | 7 [†] |
| PSL Technical Support | 1[††] |
| Local Authority | 2 |
| *Locality* | |
| West | 5 |
| East | 3 |
| North | 1 |
| Norwich | 3 |
| Norfolk and Waveney | 14 |

*1 person also a Non-Clinical Call Handler; **1 person also part of Virtual Clinical Team

[†]1 person also PSL Technical Support; [††]This person was also Central Project Support

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## B.    Patient letter

Dear xx

Your GP has identified you as someone who is more likely to be unwell if you become infected with Coronavirus. There is now a widespread outbreak of the virus and it is essential that you and those you are living with take the right steps to keep you safe.

Your General Practice will be providing extra support for patients like you who are at higher risk.

We are asking you to let us know how your health is, by using this Website ([www.nhspatient.org](www.nhspatient.org)). To do this we have provided you with a "Covid Code" at the bottom of this letter (it is called a Covid code because Coronavirus is also known as Covid-19). You can use this every day to let us know how you are. This will help us identify quickly which patients in Norfolk and Waveney are in need of additional medical support.

If you are unable to access the internet we would encourage you to ask a family member or friend to do this for you over the phone if they are not isolating with you. If you can't do this don't worry as we will continue to provide you with all of your usual support services.

Please do take a little time to look carefully at the attached brochure.

You might be one of the people who has received a letter issued by the NHS nationally identifying you as 'at risk' with a phone number to call, and/or you may have received a letter from your local council with a number to call for social support. This letter and leaflet is in addition to those important letters. It's another way your local NHS and local councils are working together to keep you as safe and well as possible.

Kind Regards

Your COVID Code is: XXXX

## C.  Patient questionnaire

## Daily Update for my Healthcare Team

## Covid Code: Z0FC

Please complete the sections below:

| | |
|---|---|
| Do you currently have a cough? | ○ Yes ○ No ● Not set |
| Do you currently have a fever or symptoms of a fever? | ○ Yes ○ No ● Not set |
| Does anyone else in your household have a cough or a fever? | ○ Yes ○ No ● Not set |
| Have you left your house since you last filled in this questionnaire? | ○ Yes ○ No ● Not set |
| Has anyone entered your house since you last filled in this questionnaire? | ○ Yes ○ No ● Not set |
| Have you ensured that you washed your hands after touching any post or deliveries and isolated these products for 48 hours. | ○ Yes ○ No ● Not set |
| Do you currently have essential supplies? | ○ Yes ○ No ● Not set |
| Do you feel that you need anyone to contact you? | ○ Yes ○ No ● Not set |
| Is there anything you would like to ask? | |

Save

**D.     Call script**



www.nhspatient.org

Script for Carrying Out a COVID-19 High Risk Assessment

Important Advice to Keep High-Risk Patients Safe

Fully Integrated with:
**Advice & Guidance**
NHS Digital Assured

*Note: Please click on image to open linked document.*

## E.       Letter to non engagers

**XX May 2020**

Dear < first name>

The local NHS in your area has set up an initiative that will enable your GP to monitor your health more closely during the Coronavirus (Covid-19) pandemic and help to keep you safe.

You have been identified by the national NHS as someone who is more likely to become unwell if you are infected with the virus. Accordingly as part of our local initiative we would like you to report your health symptoms, at least once a week or more often if you are feeling unwell, by logging on to the website www.nhspatient.org using your own unique code.

**Your Covid Code is:  <<CovidCode>>**

**What you should do now**

1.  Go to www.nhspatient.org enter your code and let us know how you are. Please do that at least once a week or more often if you are feeling unwell. If you cannot do this yourself, please ask a family member or friend to help.

2.  If you are having difficulties completing the questionnaire on the computer and you have no one who can help you then please call 01603 257258 and leave an answerphone message. This phone line will not be staffed but if you leave a message with your name, contact phone number and covid code then a member of our team will call you back to assist you with completing the questionnaire. The only purpose of this phone line is to assist those who need help in completing the questionnaire online. This phone line will be open Monday to Friday until Friday 5 June 2020.

3.  Further if we see a problem or you cannot check in daily, we might ask someone to telephone you to make sure you are alright.

**More information**

This is a new scheme from your local NHS - you may have heard about it on the news locally.

We ask you to use your special "Covid Code" to send in updates, so we know you are safe and well.  It's a great way to let us know if you have the right medicines and essential supplies such as food or if you need any additional support. If you do need help, someone will be in touch soon.

You can ask a family member or friend to do this for you over the phone, even if they are not isolating with you. If this is not possible you will be contacted by telephone.

**Why should you join in?**

We really hope you're well right now and have what you need. But if things change, we may be able to help. By telling us regularly how you are, your GP can be assured they don't need to worry. But if you, or we, spot a problem that might get worse then we may be able to help you if you wish.

**Is it worth it?**

The simple answer is yes. It's there for you just in case. As of April 27, 2020:

- 176 people who have already signed up had coronavirus symptoms but either did not know or needed medical advice - we arranged that.

- 166 people had other medical problems - we arranged for them to speak to a doctor or nurse.

- 285 needed help with their medicines - we helped them.

- 635 patients had other problems which local councils could help with.

One man, whose wife is a patient under the scheme, said: "People genuinely care that you are alright and that makes such a difference at times like these. The questionnaire is quick and easy to do so I would have no hesitation in saying to anyone who has received the letter – sign up!"

We've included in this letter a brochure providing some useful information about how to self-isolate, and some further information about how to use your Covid Code and help us stay in touch as coronavirus continues to circulate.

Please note you might be one of the people who has received a letter issued by the NHS nationally identifying you as 'at risk' with a phone number to call, and/or you may have received a letter from your local council with a number to call for non-medical support. This letter and leaflet is in addition to those important letters. It's another way your local NHS and local councils are working together to keep you as safe and well as possible.


Kind Regards,

**Dr Anoop Dhesi**
Chair, NHS Norfolk and Waveney Clinical Commissioning Group

**Dr Julian Brown**
Clinical Lead

**Dr Sally Hall**
Clinical Lead West Norfolk

**Dr Jeanine Smirl**
Clinical Lead Norwich

**Dr Karen Mitchell**
Clinical Lead Great Yarmouth and Waveney

**Dr Paul Everden**
Clinical Lead North Norfolk

## F.    Standard operating procedures North Norfolk

**NNPC Virtual Clinical Teams (VCT's) NNPC Draft Proposal**

It has been agreed nationally that there is and will be an increasing workflow in general practice. This paper will look at how NNPC's VCT can support general practice. It is underpinned by the BMA "COVID-19 - ethical issues. A guidance note"

We have been sharing best practice at a system wide level with North, East, and West in N&W.

Statements assumed by NNPC:

- Best practice, in an ideal situation, is decisions and management pathways being undertaken by GP's in a patient's own practice.
- The ultimate responsibility for a patient who is in the community rests with the registered General Practice and nominated GP within that practice.
- An individual clinician has responsibility for his/her actions.
- Communication therefore with patients own GP is imperative.
- Sharing decisions between clinicians when in uncertain times and circumstances is more likely to result in new best practice.

Ethical principles during a rapidly changing clinical environment: (from BMA ethics guidance)

- Reasonable in the circumstances.
- Based on the best evidence available at the time.
- Made in accordance with Government, NHS or employer guidance.
- Made as collaboratively as possible.
- Designed to promote safe and effective patient care as far as possible in the circumstances.

NNPC has created a team of clinicians, some of whom are retired local GP's, who are able to support general practice virtually during the Covid-19 pandemic. They will be available to offer clinical support to a variety of workflows.

Structure of the VCT

- Clinicians with different skill mix, eg, GP's, clinicians who are shielding due to own high risk, ANP's, paramedics are available to offer virtual consultations.
- A group of senior clinicians, who can support the other less senior clinicians.
- Visiting team of nurses/paramedics/GP's/HCA's possibly using tekihealth for remote consultations.
- Senior GP's supporting visiting clinicians but keeping own patients GP in the loop.

We would like General Practice to help us create a set of guidelines, steered by the above guidance, on how the NNPC VCT works with Practices to best support them.

All workflow streams (see attached diagram), once they have been delegated to the VCT, will be assessed in the same way.

1. All workstreams come to practices
2. Practices assess and then delegate to the VCT (via appointment system for each workstream)
3. VCT will then assess the required skill set (GP, ANP or paramedic etc), create a management plan (Mx) and inform GP's. The process will be as follows;
   - For straight forward work, VCT will enter into patient notes when work is completed.
   - Simple requests, such as blood tests etc, will be sent into the online TASK hub (same as presently used for I.A.) in each practice.
   - VCT will 'Teams' call on dedicated link to GP to relay and agree Mx plan, agree who completes each action within the team. The VCT will confirm actions in notification/task in clinical notes.
   - VCT will refer back to GP if it is deemed more appropriate for GP to assess and manage.
   - EPS is now switched on for GP Hubs and this will minimise prescription requests going back to practices (simple ones)
   - If complex care planning/CD scripts/syringe drivers these will be discussed and provided by the patients GP

At times where escalation is compromising GP's ability to manage workflows

- VCT to contact GP to discuss provision of more appointments where possible.
- Appointments could be prioritised to support a struggling practice due to staff shortages
- Allow movement of staff between workstreams depending on workload at VCT level

Patients in early discharge units (St Michaels,)

1. Out of area patients at St Michaels have been registered with Market Surgery otherwise patients will remain registered to their own NN practice.
2. Clinical daily management is undertaken by the ECHT.
3. The ECHT have a dedicated senior support clinician who is part of the VCT.

VCT supporting GP practice in Care Homes

1. Calls at the moment are taken by the ECHT lead nurse.
2. Patients assessed over the phone and clinical decisions are made. If the lead nurse needs help with clinical decision, then they discuss with patient's own GP. Mx plan agreed and task to GP to confirm responsibilities.
3. If GP workstreams become overrun then the appointment system for VCT can assist the ECHT as much as possible. Decision making would then work as above.

<u>VCT as first point of access. For example; in dealing with EEAST stacks at busy times (Still under discussion with EEAST).</u>

1. EEAST would have access to a joint appointment system for the registered practice and the VCT.
2. VCT triage them for clinical need and priority, referring to patient notes. VCT will then manage case in same way as above.
3. Practice could also take from the appointment list where they know the patient very well. Who takes the patient (VCT or practice) would be visible to both parties to prevent duplication.

<u>We also require guidelines on when difficult decisions need to be made due to pandemic resource pressures.</u>

This would be a very dynamic process informed by a system status barometer. Decision making would then be linked and recorded with the system status and pressures.

We suggest, in foremost that decision making is shared, and would always, where possible, involve the patients GP. We suggest that we try to follow the BMA ethical guidance, details below:

- **Equal respect:** everyone matters and everyone matters equally, but this does not mean that everyone will be treated the same
- **Respect:** keep people as informed as possible; give people the chance to express their views on matters that affect them; respect people's personal choices about care and treatment
- **Minimise the harm of the pandemic:** reduce spread, minimise disruption, learn what works
- **Fairness:** everyone matters equally. People with an equal chance of benefiting from a resource should have an equal chance of receiving it – although it is not unfair to ask people to wait if they could get the same benefit later
- **Working together:** we need to support each other, take responsibility for our own behaviour and share information appropriately
- **Reciprocity:** those who take on increased burdens should be supported in doing so

- Keeping things in proportion: information communicated must be proportionate to the risks; restrictions on rights must be proportionate to the goals
- – **Flexibility:** plans must be adaptable to changing circumstances
- – **Open and transparent decision-making:** good decisions will be as inclusive, transparent and reasonable as possible. They should be rational, evidence-based, the result of a reasonable process and practical in the circumstances.
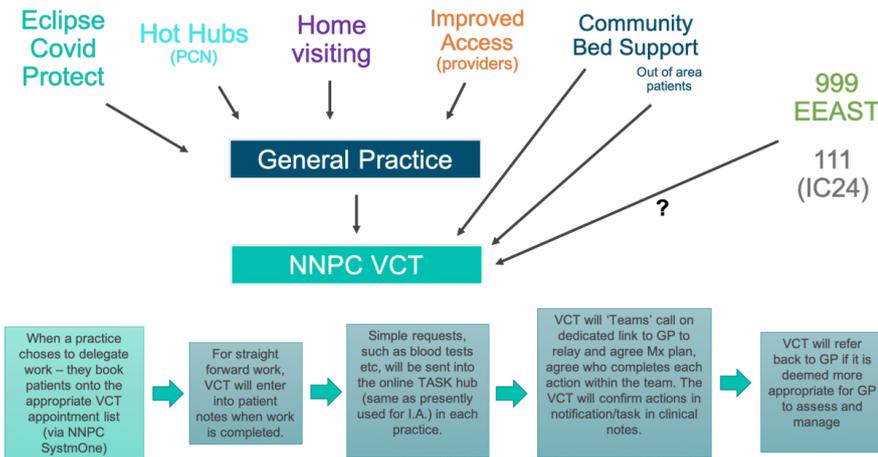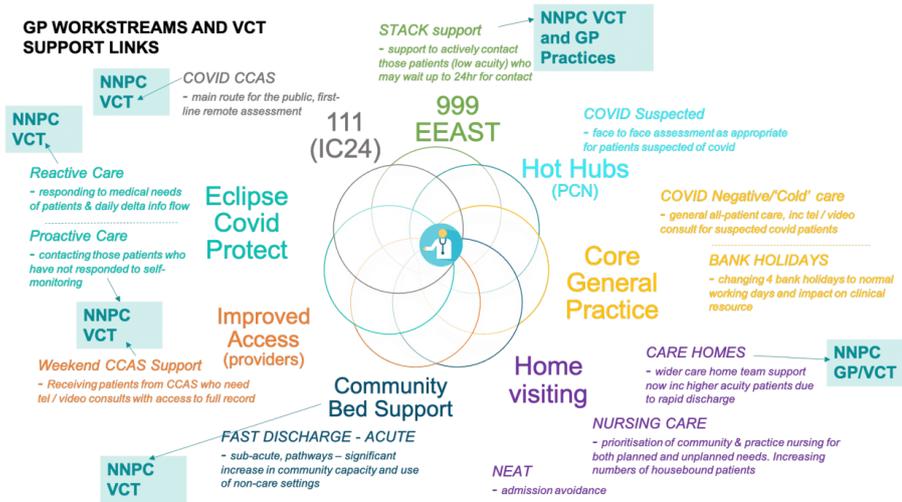
**G.      COVID PROTECT: Centrally Optimising Vulnerable Individuals through Data, Overview by Prescribing Services Ltd.**



*Note: Please click on image to open linked document.*

**H.** **Evaluation of the *Covid Protect* Programme: Report by Norfolk and Suffolk Primary and Community Care Research Office**



# Evaluation of the COVID Protect Programme

September 2020

*Note: Please click on image to open linked document.*