North West Anglia NHS Foundation Trust

REPORT TO THE TRUST BOARD (PUBLIC)

TITLE	Lessons Learned Review – Post Peak
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EXECUTIVE SPONSOR	Louise Tibbert, Chief People Officer
DATE OF MEETING	30 November 2020
PRESENTED FOR	Information

PURPOSE OF THE REPORT

To provide the Trust Board with an overview of the Covid-19 Lessons Learned Activity and key themes and recommendations from this activity to support preparations for any future incident.

EXECUTIVE SUMMARY

Covid-19 first became known as an infectious disease in December 2019 and has subsequently led to a worldwide pandemic. Locally North West Anglia NHS Foundation Trust (NWAFT) has received in excess of 1,000+ Covid-19 positive patients and sadly over 300 of these patients lost their lives to Covid-19.

The Trust executive team commissioned a post-peak learning exercise to identify key learnings and understand how the trust has responded within the incident with the aim of improving how the Trust may respond in the future.

This report outlines the lessons learned activity, feedback, themes and recommendations to inform planning for the continued response to the pandemic and any future incidents.

RECOMMENDATIONS

1. *That PPC & Board accept and support the attached recommendations*

STRATEGIC GOALS THIS REPORT SUPPORTS *(Check all that apply)*

Delivering outstanding care and experience	✓
Recruiting developing and retaining our workforce	✓
Improving and developing our services and infrastructure	✓
Working together with local health and social care providers	☐
Delivering financial sustainability	☐

RISKS RELEVANT TO THE PAPER

Risk ID	Risk Description
NONE	NONE

OTHER IMPLICATIONS OF THE PAPER

Legal/ Regulatory Relevance:	None
NHS Constitution Delivery	
Freedom of Information Release	This report can be released under the Freedom of information Act 2000

Equality and Diversity Implications *(Check all that apply)*								
Age	Gender	Ethnicity	Disability	Pregnancy/ Maternity	Marriage/ Civil Partnership	Religion/ Belief	Sexual Orientation	Gender Reassignment
✓	✓	✓	✓	✓	☐	☐	☐	☐
Additional comments								

1. BACKGROUND

1.1 The Trust started to make preparations for a major incident in early March 2020, closing departments and redeploying our workforce to our most needed areas. Whilst transmissions in the area have been moderate, and was not required to utilise the maximum capacity prepared for in terms of caring for patients requiring ITU care the Trust faced significant staffing challenges at the pandemic peak.

As identified in the executive summary, the impact of the worldwide Covid-19 pandemic is far reaching and expectations on the health system have been unprecedented. While it is too soon for the Trust to begin considering and understanding the full extent of the

impact of Covid-19, the passing of the first peak of this pandemic provide an opportunity for the Trust to reflect on the experience so far and to identify some of the key learning which can be used to inform future planning for further potential waves of infection, for winter preparedness and identify where improvements can be made.

The Workforce and Organisational Development Team (W/F&OD) and Emergency Preparedness Resilience and Response team (EPRR) have worked in partnership to lead this review and establish a multi- disciplinary task and finish group to engage the delivery of the activity, analyse the data and prepare this report.

1.2 During the period covered by the first wave of Covid-19, the Trust has provided care for in excess of one thousand confirmed Covid-19 patients. Of these, to date over 300 patients lost their lives to Covid-19.

1.3 In March 2020, the country went into lockdown and the government issued shielding instructions for those at higher risk from Covid-19. In addition, the requirement to undertake risk assessments (and mitigations) the need for significant adjustments for a large proportion of our workforce has created significant challenges in resourcing the right people with the right skills into the right role and place to provide safe and quality care for our patients have presented. As a result the Trust has seen sickness absence levels steadily increase to in excess of 7% with over 50% of this at times being Covid-19 related. As a result our workforce had to be rapidly upskilled and redeployed to unfamiliar workplaces and context creating fatigue and anxiety.

1.4 The very nature of incident management requires a command and control structure, and whilst this is necessary in an incident we need to be mindful of how this impacts engagement and influences our culture and how we work. This style and approach is in complete contradiction to the culture and leadership approach the Trust aspires to achieve.

2. SCOPE OF LESSONS LEARNED ACTIVITY

2.1 The scope of the activity aimed to establish 5 key aspects for learning lessons for the future. Key themed questions during the activities focussed on whether-

a) The Trust communications used were an effective way of sharing information with our workforce?
b) The command and control arrangements and processes were effective for coordinating and responding to COVID-19.
c) Our staff felt supported and safe by their immediate and Trust leaders?
d) Any changes introduced during the first peak in terms of patient care or working practice, that staff had retained or would like to see continue in the future?
e) There were any areas of improvement the Trust needed to focus on in preparation for and response to a second wave of infection?

2.2 To ensure that this exercise was inclusive to all staff the lessons learned methods and activity took many forms and therefore both face to face, paper and digital approaches were applied in order to capture maximum staff engagement. The digital/virtual activity worked particularly well and ensured engagement of key staff whilst adhering to social distancing rules during the pandemic, the activity included;

- Online surveys (Targeted Have Your Say, Feedback Friday)
- Paper surveys (COVID Experiences, Debrief Questionnaire, Opportunity for Change Questionnaire)
- Live listening events (online and in person)
- Feedback from wobble rooms (anonymised)
- Divisional Feedback
- Divisional & Team Debrief sessions

2.3 The engagement of these activities was varied but well responded to with good representation across most of our staffing disciplines and levels. Over 1,634 individuals participated in questionnaires and 16 group activities were undertaken. Of note 1,634 people participated in the Quarterly staff survey which have specific Covid-19 related questions with free text on how to improve and for feedback. Engagement in this was very positive and feedback has been valuable.

Source	Individual	Group
COVID Debrief Lessons Learned Guidance	3	16
COVID Experiences Questionnaire - FSS and Agency	0	0
COVID Experiences Questionnaire - YVM Survey Hard copy	88	0
COVID Experiences Questionnaire - YVM Survey Monkey	61	0
An opportunity for change - EMED	64	0
Virtual Listening Events	14	0
Live Listening Events	3	0
Feedback Friday Surveys	539	0
Quarter 1 Staff Survey Have Your Say	862	0
Total	1,634	16

2.4 This report focuses on 6 key themes for the feedback, improvements and recommendations:

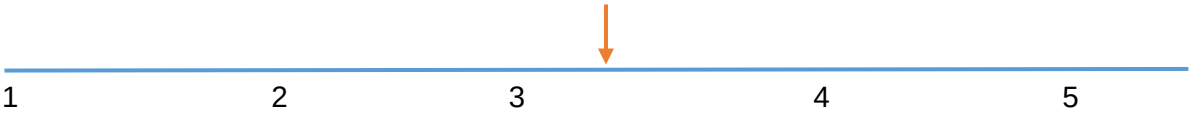
- Communications & Engagement
- Leadership
- Education & Redeployment
- Health & Well-Being
- Digital Technology, Equipment and Supplies
- Care Quality & Patient Experience

3. FINDINGS

3.1 Overall feedback was overwhelmingly positive with some creative and patient focussed examples of how staff were able to continue to provide compassionate patient care in the face of adversity. There were however also examples of where as a Trust improvements need to be put in place to ensure our staff are supported through the next phase of the pandemic. Encouragingly, some of the great work, improvements and new ways of working have already been embedded to ensure that immediate benefits can be realised and recommendations and actions detailed in item 4 below highlight the plan to address any other issues raised.

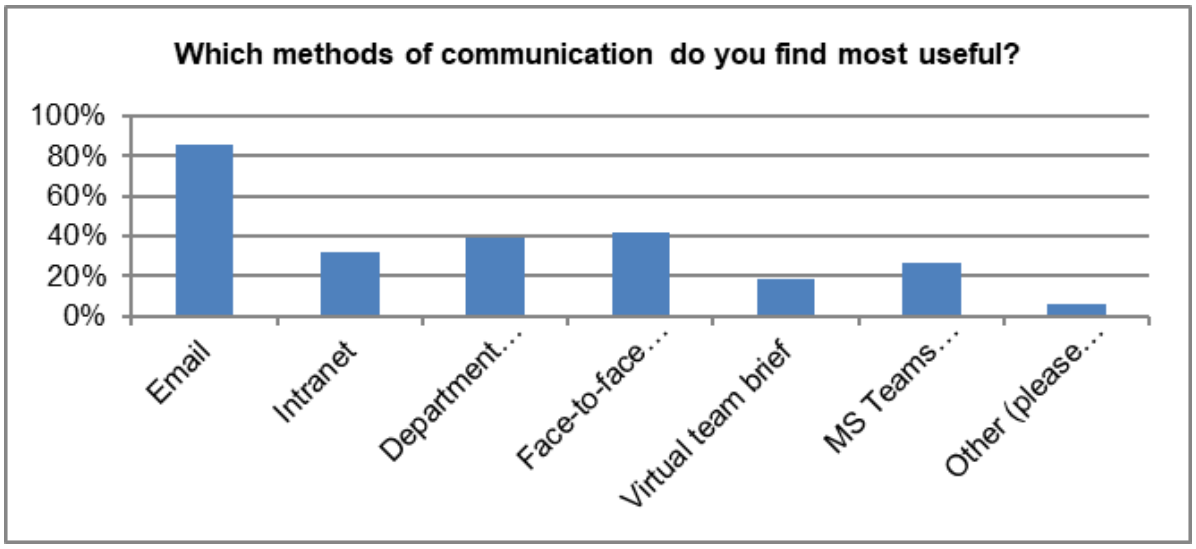
3.2 Communications & Engagement

Using a sliding scale staff were asked how useful did they find the Trust communications during the pandemic. The average response equated to 3.2.



Participants were asked to consider how effective communications were throughout the pandemic and how this helped them understand the processes and rationale for actions taken.

Participants were also encouraged to propose their own ideas of how communication and engagement could be improved.



Key themes from the activity conducted included:

- Different and volume of messages in a short space of time caused confusion.
- Information needs to be clear, honest and easy to read (less jargon)
- Department meetings were not consistent so messages were not disseminated effectively.

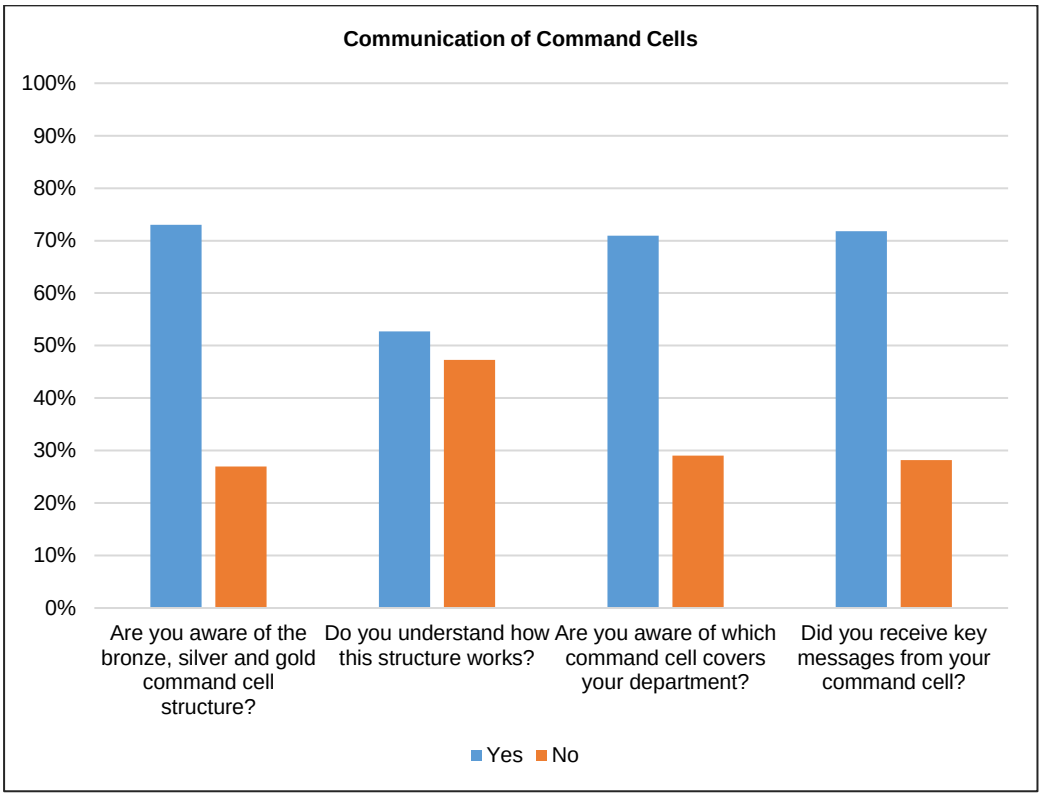
- Staff that were shielding or working from home didn't feel that they got the messages effectively
- One bulletin for all news once a day would be helpful which is then saved on Connect or a private internet page that is accessible for all staff
- Request to use all methods of digital media to communicate (not everyone can get to emails) ie) Pop ups on screens; Facebook other social media; texts etc.

When asked how effective were the messages staff received from their command cell? The average answer was 3.4.

1 2 3 4 5

Ineffective Highly Effective

Feedback demonstrates that the awareness of the cells was quite high, however some staff were unsure how the structure worked. The general theme through the comments was that there was a lack of consistency in the messages with regards to them getting to the front line staff and the cells communicating the same messages/guidance.



Staff commented that whilst there were opportunities to receive consistent high level messages through Trust wide communications this was not felt so at local level. Staff reported that in some areas communication was strong and staff were aware of the structure and rational for decision making however on the whole frontline staff felt out of the loop.

3.3 Leadership

Overall staff felt unclear of what the command and control leadership structure was and who it was. Whilst they understood the role of EPRR some staff did not understand other's roles in the process and how that impacted their role.

As the results above show, the awareness of the bronze cells was quite high, however some staff were unsure how the structure works and how local leadership were represented and involved in wider trust decision making. Suggestions to improve this included sharing clear structures of the command and control approach and agreeing consistent ways of communicating locally decisions made and rationale especially in relation to safety measures such as Personal Protective Equipment.

Within the Quarter 1 Staff Survey – Have Your Say, there was a perception particularly from the Hinchingbrooke site that all senior leadership had moved to working at home, and did not provide visible leadership on site. In addition staff felt the lack of consistency of allowing staff to work from home was not led well and this created anxiety and negative impact in morale.

Consideration of future improvements included the need to ensure that there was clear senior leadership visibility across all sites, more regular updates from executives and a greater focus on listening to staffs ideas and feedback during critical incidents.

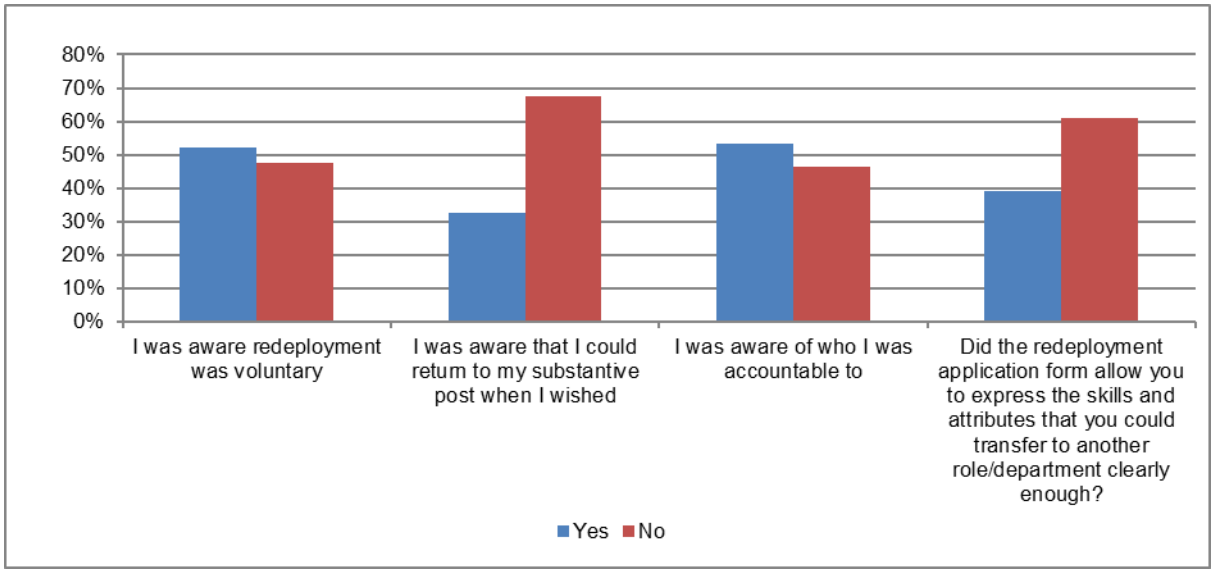
3.4 Education & Redeployment

228 people in the following roles participated in the education and re-deployment feedback survey.

Role Type	
Nursing & Midwifery Registered	41.2%
Administrative & Clerical	30.7%
Additional Clinical Services	11.0%
Additional Professional Scientific & Technical	4.4%
Medical & Dental	4.4%
Healthcare Scientists	3.5%
Student	2.6%
Estates & Ancillary	2.2%

Nearly 30% of the respondents were re-deployed to another area to support the Trust's pandemic response across a number of areas. The majority were clinically redeployed to Critical Care Units, Acute Assessment Units other ward areas however there were a proportion of these also redeployed to Research and Development, Patient Safety, the mortuary and other corporate teams.

Over half (54%) felt that redeployment was a positive experience and we have received many positive feedback captions from staff and case studies (see Appendix 1) who were reignited in their career ambitions as a result of their experience however some staff felt pressured to be redeployed and felt this was not an option but a directive – regardless of their fears or anxiety.



Specific anxieties related to confidence and inconsistency in their training and upskilling experience and matching process. Improvement suggestions from staff included more care and attention with the redeployment process and discussion and a recognition regarding individual situations that may impact of motivation for redeployment.

The deployment of registered staff who were shielding was inconsistent and therefore the experience of those shielding or working at home was varied. Consideration to how these staff members were utilised led to feelings of isolation and a lack of being valued with these cohorts of staff. There has however been successful projects utilising some staff towards the end of the first wave, including a project led by the patient experience team to ask these staff members to buddy with wards and act as a liaison between the ward and families to keep families up to date with patients progress.

For staff shielding at home the redeployment experience was more mixed with staff feeding back in the Staff Survey – "Have Your Say" that some felt incredibly isolated and support and communication from local leadership and managers ranged from zero to highly supportive. Despite there being poor feedback around equal access to agile working initially, the wholly positive aspect of the shielded staff who were able to work from home was the positive impact and steps the trust had taken to enable staff to work at home and in an agile way.

Overwhelmingly the feedback from the debrief sessions with staff redeployed to Critical Care was that whilst there had been challenges and anxieties, staff felt the management and structure of the debrief sessions held by the Head of Nursing and the OD/Redeployment lead was hugely supportive and was instrumental in providing staff with the opportunity to feedback, be recognised and valued and to offer to cover future challenges in Critical Care and ITU.

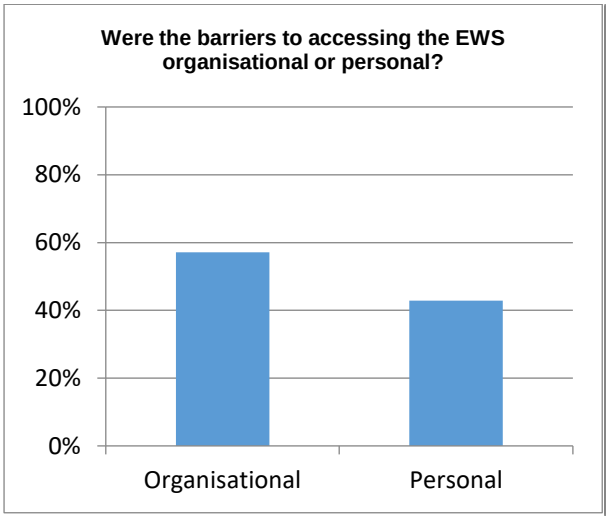
3.5 Health & Well-Being

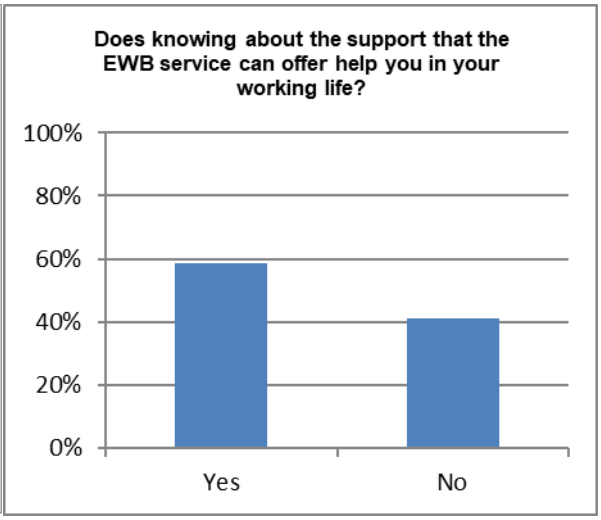
Most participants who participated in the feedback activity were at work working in a clinical (56%) or non-clinical role (36%) with some working from home (3%) or shielding (5%).

Emotional Wellbeing Service (EWS)

The Emotional Wellbeing Service (EWS) was set up in response to the pandemic, to offer support to all members of staff by way of 1:1 virtual or face to face appointments with a qualified clinician in a safe, confidential, neutral, non-judgemental space, or to access the SALS helpline, online self-help tools and the wobble rooms (in some cases staff were referred to occupational health for further support).

Results from the survey demonstrate that 97% of participants were aware of the Emotional Wellbeing Service (EWS) and 60% accessed it in some way.





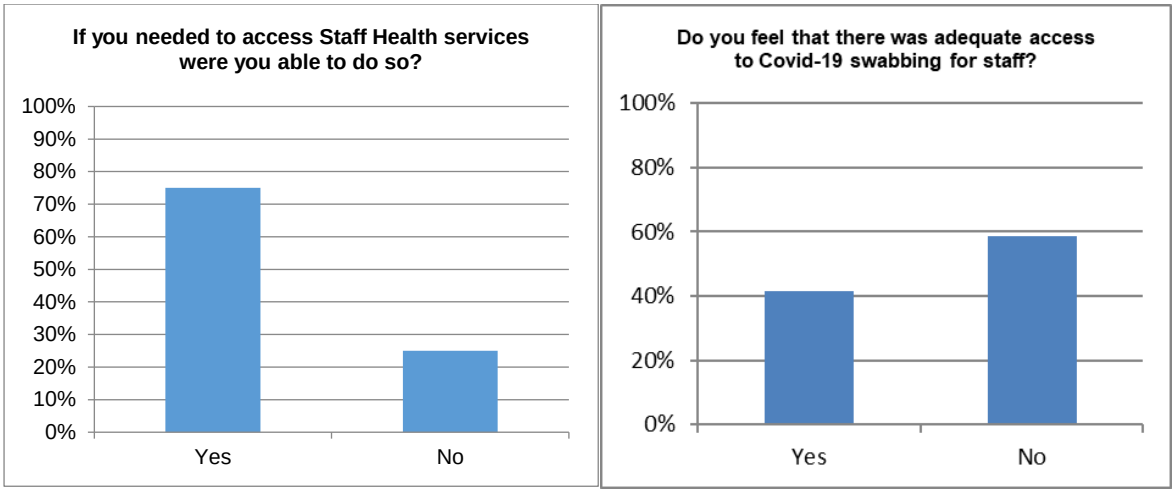
Some staff who completed the survey felt they found it hard to access the EWS service citing difficulty to attend due to staffing shortages and shift patterns and times. Feedback on the overall service was very supportive and positive. Staff suggested future consideration needed to take into account the availability of this predominantly 9-5 service and the needs of staff.

Staff Health/Swabbing

In considering access to staff swabbing and occupational health support staff felt that access was limited and there was confusion over how to and the conditions for accessing swabbing.

Staff felt swabbing should have been undertaken sooner and before the 3-5 day window. Some staff reported that other Trusts providing swabbing on the day of symptoms and could not understand the difference of access across the system.

Staff also suggested that there was a lot of confusion in the divisions and across the Trust regarding the process to be swabbed and reported going to colleagues or national swabbing centres as they wanted to be swabbed sooner to alleviate anxiety and return to work.



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Access to health services was on the whole good and staff recognised that in the midst of a pandemic all services were stretched. Staff redeployed to the occupational health team from other areas of the Trust ensured that the occupational health team were able to continue many of the services support staff in addition to managing the large pressures around swabbing and testing. (See Appendix 3)

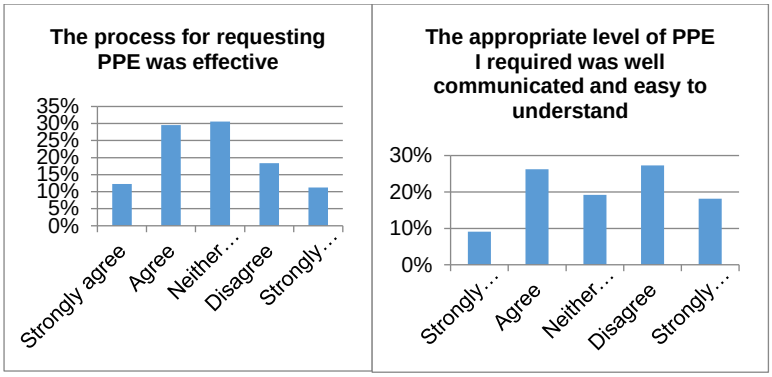
|Improvement suggestions include that direct access to occupational health for swabbing would be easier and swabbing on day 1 of symptoms would alleviate anxiety and staffing issues.

Further improvements suggested clearer and stronger support and guidance for shielding staff with clear plans of how they can be supported to work from home alongside clearer approach from managers in the application of this would be helpful.

3.6 Digital Equipment, Technology and Supplies

At the height of the pandemic, there were challenges associated with Protective Personal Equipment (PPE), however throughout the Feedback Friday survey results, staff consistently praised the stores team and provided overwhelmingly positive comments.

Staff acknowledged via Staff Survey – Have Your Say that the confusion around changes to requirements and supply were brought about by the national challenges and constant changes however staff reported feeling staff safety was not a priority and felt this was not managed well locally with reports of managers' behaviours and response not in keeping Trust values. Over 37% reported they didn't feel able to raise or challenge the supply issues and concerns. Other key elements of concerns raised were around the supply of hand gel, wipes to comply with the Trust infection control guidance.



In addition to the equipment, as reported above there were initial challenges to equip staff to work from home and this has resulted in staff feeling that they were not fairly treated in the prioritisation of kit being provided and in managers consistency in agreeing working from home conditions. Specific feedback focussed on the lack of clear communication and consistency in messaging around the rational for prioritisation and application of the process.

Staff recognised that the use of IT has fast-tracked new patient care models by using technology to treat and consult with patient. Staff have readily acknowledged through their feedback that despite the initial pain of this transition the Trusts IT department has achieved phenomenal steps forward in supporting staff to work differently with patients, in an agile way and see this as one of **the** most positive aspects to come from the pandemic in terms of future ways of working.

Improvement for the future in these areas staff felt need to include more supportive approaches from leaders and managers to address staff concerns and consistency in applying an agile process and approach to improve the staff and patients experience.

3.7 Care Quality & Patient Experience

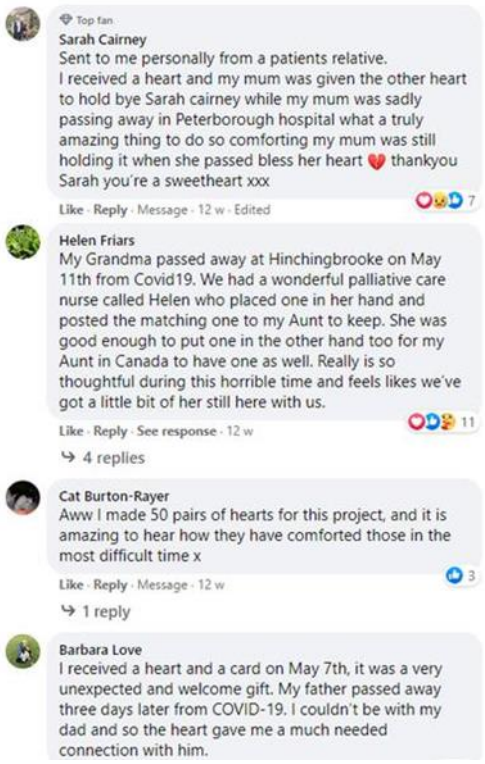
Whilst there has been feedback throughout the report from staff on their ability to undertake their role despite the many challenges that the pandemic has brought there has also been the opportunity to think more creatively about how patient care and quality is achieved.

During the height of the pandemic visiting was heavily restricted in accordance with government guidelines to enable the safety of our patients and staff. Results from the engagement of staff show that Skype has been used on the wards mainly for patients to communicate with relatives but it has also been utilised by the Chaplaincy Service and for staff to communicate with outside agencies with regards to patient care and planning. In Appendix 2 the use of technology to provide high standards of care towards our patients and their families provides an excellent example of how staff adapted to the crises to provide caring and compassionate care for our patients.

The Trust Communications team launched an initiative called ‘letter to loved ones’. This initiative aimed to help family members and friends keep in touch with patients. More than 300 letters have been delivered. One gentleman who wrote several letters to his elderly mother during her hospital stay said:

“Thank you so much for passing on my emailed letter to my mother; although she was very sleepy and eventually succumbed to Covid-19, I believe she would have heard and been comforted by hearing from her family.”

Finally, the Twin Hearts Project was launched to support families unable to visit their loved ones and provided with pairs knitted hearts to help them feel connected. More than 250 pairs of hearts have now been shared with patients and their loved ones since the project started in early April.



4. RECOMMENDATIONS

4.1 To strengthen the **communications to and engagement of** staff through further incidents in is recommended that the following are implemented:

4.1..1 Develop one daily Covid bulletin to ensure all information is in one place and communicated regularly and to all staff.

4.1..2 To ensure that communication bulletins are accessible to all staff including those working at home – therefore explore the opportunity to have an "extranet" that is secure but that all staff can access.

4.1..3 To consider other methods of digital communication other than "email" – ie screen pop ups, social media and text bulletins to relieve the strain of email fatigue and support staff who have limited capacity to access emails.

4.1..4 Daily team briefings to ensure staff have a face to face summarised consistent update and opportunity to clarify concerns and queries.

4.2 To improve the **leadership** within future incidents the following recommendations should be implemented:

4.2..1 The Command and Control structures and roles and responsibilities should be widely communicated to all staff.

4.2..2 Local Bronze cell membership and terms of reference should be communicated throughout divisions to ensure staff are aware how they and their areas are represented in the incident.

4.2..3 Local Bronze cells to communicate regularly (minimum weekly) with staff in divisions to provide updates on local decisions and rationale.

4.2..4 Regular min weekly) face to face and virtual drop in's with executive members across all sites to provide visible leadership and communication with staff. (whilst maintaining compliance with infection control and social distancing measures).

4.2..5 Daily local leadership face to face and virtual team briefs to ensure local teams are consistently clear on the key messages, actions and decisions for the day.

4.2..6 The provision and consistent application of policies and procedures that support staff to undertake their duties (ie in an agile way).

4.3 To strengthen the approach to **education and redeployment** the following is recommended for implementation;

4.3..1 Where possible greater time and care is provided to staff to complete upskilling and redeployment to help staff manage the change and greater expectations.

4.3..2 That all staff required to be redeployed are treated with respect and compassion and supported in their choice if the redeployment is not within the current scope of practice.

4.3..3 Strengthen the upskilling programme for staff who are shielding or unable to work within the hospital sites.

4.3..4 The development of a redeployment strategy and policy to support the effective redeployment of staff in the future.

4.3..5 Consider roles and tasks that can be undertaken by registered staff shielding or working at home to maximise the use of resources and continued patient care.

4.3..6 The introduction of an agile/flexible working strategy and policy to ensure staff are clear regarding the conditions and are supported consistently to work in an agile way.

4.3..7 That a full and comprehensive skills audit is undertaken to develop a corporate and centrally held record of skills and previous experience to ensure in the future there is a strategic approach to deploying the workforce.

4.3..8 That a continuous programme of upskilling and secondments and bank shifts are offered to staff who were redeployed to ensure they can continue to keep their practice and skills up to date and to remove the need to rapidly upskill.

4.4 To further improve how the Trust can support the **Health & Well-Being** offer to staff the following should be implemented:

4.4..1 Formalisation of the emotional health & well-being offer with the production of a robust strategy and action plan that includes provision of face to face support, continuation of wobble rooms and the rapid access mental health support.

4.4..2 Consideration given to providing an emotional health and well-being offer that is accessible for all staff rather than only in core hours.

4.4..3 Staff swabbing requests to go directly to occupational health to ensure the process is swift and confusion free.

4.4..4 Consideration as to the timeline for swabbing be reviewed to swab on day of symptoms – similar to the process other Trusts and agencies are applying in the region.

4.4..5 Clarity on guidance for homeworking and rapid access to Display Screen Equipment assessment and other needs.

4.4..6 Greater support for shielding staff to ensure they feel connected and included in the incident.

4.4..7 That staff have a minimum of monthly risk assessments review to ensure that these are up to date and staff feel fully supported.

4.5 To further improve areas that relate to the **Digital Technology, Equipment and Supplies** the following should be considered for implementation;

4.5..1 That clear and honest communications are shared in terms of PPE and other equipment supply and issues.

4.5..2 That clear guidance and training is provided in relation to the use of IT and other digital equipment to support staff to utilise the equipment to its maximum opportunity and that staff feel supported to work agile.

4.5..3 That digital technology is maximised to lock in new ways of working with patients and support efficient and effective practice.

4.5..4 That there is a robust and responsive process and plan in place for the deployment of technology and equipment to support and enable staff to work in an agile way.

4.6 To further improve the approach to **care quality and patient experience** it is suggested the following improvements should be considered;

4.6..1 The use of technology and digital media to support clinicians, patients and carers to communicate more effectively and compassionately should continue, this includes the use of i-pads, sign-live etc.

4.6..2 A clear communication and engagement strategy and plan for communicating and engaging with patients and their families be developed to support any future incident.

4.6..3 That current engagement within the patient experience continues including the co-production of patient services and strategies via the patient and public voice partnership group.

4.6..4 That the use of technology and virtual clinics to offer more effective and responsive patient services should be further developed.

4.6..5 A range of tools be developed or enhanced to improve the patient experience this includes Attend anywhere – virtual clinics and the use of interpreters should continue to be embedded.

4.6..6 The use of volunteer continue to be considered a valued resource during an incident and a strategy and action plan to deploy these volunteers in an incident should be considered.

5. SUMMARY

The above recommendations are not exhaustive, and there were many amazing stories of how staff have risen to the challenge of the pandemic, committing huge discretionary effort to the Trust and their patients and colleagues. The case studies attached in the appendices are only two examples of the impact and opportunities that have emerged. Substantial work has already taken place to enact some of these recommendation and as feedback was received processes and practice was developed and improved along the way. A full action plan is in development and it is requested that the committee support and agree these recommendations to allow the full development of a robust action plan.

Appendix 1– case study

Case Study – Critical care experience as an HCA and student nurse

Towards the end of March 2020 the Trust's preparations for the supporting the local community through the Covid-19 pandemic began to gain momentum. Staff working in ward and clinic areas were asked to consider moving to the Critical Care unit in order to help to manage the expected increase in number and acuity of patients.

At this time, Charlotte Raynor was working as an HCA on A4 and studying as a nursing student. Charlotte had previous experience of the Critical Care Outreach Team and aspirations to work in a Critical Care setting on qualification. As such, she saw this as an ideal opportunity to gain experience and insight in to the speciality and offered to be part of the redeployment.

Although Charlotte offered to go she did have her reservations and concerns and these were more centred on her home life. With two children at home, one still quite young, she had to consider the potential consequences for her family. Her partner was also a key worker which again, increased the risk to the household. Despite this she decided to go ahead with the redeployment.

Initially Charlotte transferred in her HCA role. She worked long days in this role, often as an 'outside runner' being entrusted with collecting supplies and equipment required within the bays or rooms where the Covid positive patients were cared for. This system supported infection prevention and control guidance. Charlotte was also able to gain some experience 'inside' working directly with the patient group.

Charlotte was at the beginning of her third year of student nurse training and was due to be sent on placement. She requested that her placement area be Critical Care and the unit were happy to support. She remained on the unit for a further six weeks and was able to gain a wider knowledge base, not only with patients affected by Covid-19 but also with other patients requiring intensive care.

Charlotte speaks very positively about her HCA and student experiences on the Critical Care

Unit. Every day she learnt something new and was supported to expand on her experiences, the core critical care staff knew she was there as a student and supported her in all aspects

of her role, ensuring she had the opportunity to observe, question and increase her knowledge at every opportunity.

Despite her positive experience, she does acknowledge and talks very eloquently about trained staff who were redeployed from other, less acute areas. She talks about how they were thrown in and must have been ‘so stressed’ to be working outside of their usual comfort zone. The change from their routine role to critical care is such a big step that, at times, Charlotte says they ‘looked broken.’ She shows great empathy for registrants in this position.

At the end of her student placemat Charlotte continued to do HCA shifts on critical care. She has nothing but positive messages about the support she received, she never once, even on the very early shifts, felt she was not part of the team. In her own words ‘the staff were all lovely’ which says a lot about the team they are as it is always difficult teaching other staff in such stressful circumstances. She ‘loved it’ and was ‘genuinely gutted’ to move on. Although there were tears and uncertainty she always felt supported and the opportunity to work in the unit is not one she would have wanted to pass up. In terms of learning opportunities she was able to visit the Main Operating Theatre and gained valuable insights by observing tracheostomy and brain stem testing prior to organ retrieval.

Charlotte is currently working back on her base ward and ‘happy to be home’. She has a job offer from intensive care at Royal Papworth, her final student placement starts this month and she continues to work towards qualification.

Appendix 2

Case Study – The perfect MDT Team

This case study illustrates an inspirational example of multi-disciplinary teamwork, care and compassion within the Critical Care environment. This case study is centred around one particular patient and the care the patient received in the last days of life.

At the point of admission the patient had only been present in this county for a three month period and was living with colleagues in a multi-occupancy household. All the patients' family and friends remained overseas, separated from him. The patient had a large family and their spouse remained overseas caring for their children, some of whom were still quite young with older siblings over a wide spectrum of ages.

The patient was admitted following a period of feeling generally unwell, past medical history including immunosuppressant therapy put the patient at a high risk from coronavirus. Relatively early into the patient's admission to the Unit their faith, spiritual and religious beliefs were discussed to ensure care could be personalised to meet all the needs of the patient.

The patient and team developed a strong relationship during the patient's admission. It was clear the patient took great comfort in being able to maintain a sense of normality despite the difficult circumstances and took joy and comfort in talking about their wider family, spouse and children. Every effort was made to spend time talking and listening to the patient.

Sadly, despite all the care given, the MDT were unable to avoid discussions around end of life care as the patient was approaching the last days of life. On the day the patient passed away the team caring for him have been described as having the 'perfect MDT approach'. Not only were the patient's terminal and palliative symptoms 'perfectly managed' but also the patient's traditions, religious and cultural beliefs were respected and supported by the team in those last hours and after passing.

The patient was nursed in a side room allowing privacy and dignity to be maintained. This

enabled the patient's bed to be moved to a position which ensured the patient's religious and cultural beliefs were met. The team were able to use technology to reach out to the patient's family. The use of video calling meant that the patient and their family were able to spend time as together as it was possible to be, during those last hours. The family was therefore able to see and be a part of supporting the patient in their last hours. Part of the patient's religion was for skin to skin contact during this time and the team made every effort to be holding hands as close to skin to skin as they were able to do given the circumstances. The family were able to see this via video link and gain some comfort from it and one of the team was able to use their linguistic skills to speak to the patient's spouse in their native language. Support was also provided to the patient and the team from the Chaplaincy. The family were with the patient, 'virtually', at the time of passing.

Following the patient's passing this level of care was sustained by the chaplaincy team and the mortuary team in terms of ensuring the patient's religious beliefs were supported and fulfilled regarding time frames to burial. Members of the Critical Care team were able to attend the funeral and meet the colleagues the patient had been living with and provide them support and comfort.

A number of staff were involved in the care provided to this patient, their family and their friends. These include:

Tom Franklin-Payne

Appendix 3

Case Study – Respiratory Investigations Team

In March, as all non-urgent OPD activity halted, the cross site Respiratory Investigations Team began to plan for the potential of being redeployed to support NWAFT Covid-19 response.

The team completed a skills gap analysis and developed a competency booklet aimedat upskilling the whole team appropriately. Members of the team completed cannulation and venepuncture training, non-invasive ventilation training, shadowed ward rounds, spent time with respiratory nurse specialists and in CCU and attended upskill training to support ward areas.

In addition to this they made significant changes to their working practices and working hours. This allowed them to ensure cover for a once a week urgent list in OPD as well as the possibility of a four day redeployment with staff cover to allow for potential sickness absence.

As the situation developed it became clear the team were unlikely to be redeployed to ward areas therefore, they began to look for other areas where they could support. This led to them supporting the OH team and staff redeployed from other areas in the Covid-19 swabbing process on both sites for a period of months as well as upskilling to complete FIT testing and continue to complete hundreds of tests.

As the Trust began to move out of the peak of the pandemic and routine service delivery began to be reintroduced the team redesigned their services in order to utilise the new skills they had learned. The patient pathway has been streamlined so that more of the investigations required can be completed by the team during one visit to the hospital. Additionally there is now a dedicated children and young people's list with Consultant cover from Paediatric OPD. The children have previously learned to do lung function tests using the 'Huffing Puffin' where they would attempt to blow the puffin down. This has changed in that the Puffin now has a specially made PPE outfit which the children use to dress him up, allowing them to become familiar with staff wearing full PPE during consultations. They are

still able to attempt to blow him down once he is safely dressed in his PPE.

The Team continue to innovate and are looking at revamping the Respiratory investigations Service by having three teams: a team based at PCH, a team based at Hinchingbrooke and a home based team to reduce the footfall through the departments. In addition to this a high risk member of staff was redeployed to access services for almost six months. On their return they were able to bring back new learning from that team and environment which is now helping to streamline Respiratory Investigations processes.

Recently they have launched a new drive through respiratory clinic which allows patients the opportunity to have lung function tests without leaving their vehicle. NWAFT is one of the first Trust's in the county to offer this service.