

# Spotlight

## HEALTHCARE: PRIORITIES IN A PANDEMIC

Luke Evans MP / Jeanelle de Gruchy / Munira Wilson MP





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# Difficult choices in an ongoing crisis



It has almost become cliché to talk about the heroic efforts of the National Health Service. Whether it's the former ritual of the Thursday night applause or the "thank you NHS" pictures hung in windows across the country, lauding the bravery of front-line NHS staff has become synonymous with the Covid-19 outbreak. But as the new normal starts to feel old, as autumn sets in, and as a second wave and local lockdowns look increasingly likely, it has also become cliché that lauding heroism isn't enough. Front-line healthcare staff continue to work long hours under great pressure, and at risk.

According to the latest NHS Employers report from 2019 – before the pandemic – stress accounted for a third of all sickness absences among staff, costing the service between £300m and £400m per year (see page 28). The NHS has shown itself to be incredibly resilient throughout the crisis, but coronavirus restrictions – whether the wearing of PPE or the need to social distance – only add to the strain.

Maternity care is one example of where the difficult task of keeping staff and patients safe while maintaining services has had some unintended consequences. Visiting restrictions, which have varied from hospital to hospital, meant that some women have gone unaccompanied to antenatal scans, or even for much of labour. (see page 18).

Last week, when NHS England issued new guidance encouraging trusts to relax their rules, the Royal College of Midwives (RCM) stated: "Visiting restrictions during the pandemic have been challenging for everybody, particularly for pregnant women and their families at an incredibly important and transformative time in their lives." The RCM also highlighted how difficult it had been for staff, who had "experienced some aggression from a small minority of visitors, unhappy and confused with varying and changing guidance".

There are few phrases drier and more reminiscent of the unfulfilled promises of bureaucracy than "impact assessment". But across the NHS the effect of pandemic measures on patients must be evaluated and acted upon. The phrase "lessons learned" is another cliché. But as we head for our first coronavirus winter, health services must look at what worked – and what didn't – the first time around. ●

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**Dr Luke Evans, MP for Hinckley and Bosworth, on how coronavirus has forced the NHS to modernise**

# Could the pandemic finally signal the end of the fax machine?



**B**eing born into a medical family, my father a GP and mother a nurse, I couldn't help but become aware of the National Health Service at a very young age. A childhood growing up with brothers who, like me, would go on to become doctors, and in my case to marry a GP, would cultivate a deep personal affection for the most treasured of all public services. And while I care deeply about the free at the point of care principles originating in The Beveridge Report, founded by Aneurin Bevan and protected by Conservative governments for the majority of time since, I am also acutely conscious that the NHS has its failings too.

Perhaps chief among those failings, and one that you will hear NHS staff talk about more than any other, is the overwhelming difficulties that you face in trying to effect change.

The health service is a leviathan of an organisation, so much so that even when the need for change is obvious the practical implications of delivering it have historically been glacial.

In many ways coronavirus has, by

necessity, changed that. Where in the past a technical development may have been discussed for many months the decision of the Prime Minister in March to lock the country down meant that innovation had to take place overnight. GPs who had been planning for the adoption of telemedicine for months and years, and who had not made the step because not all risks had been mitigated, were forced into telephone consultation within days. It is astonishing to contemplate that before lockdown only 3 per cent of GP surgeries were capable of offering video consultations. That percentage has now risen to the high 90s.

Secondary care has empowered clinicians to make swift decisions to

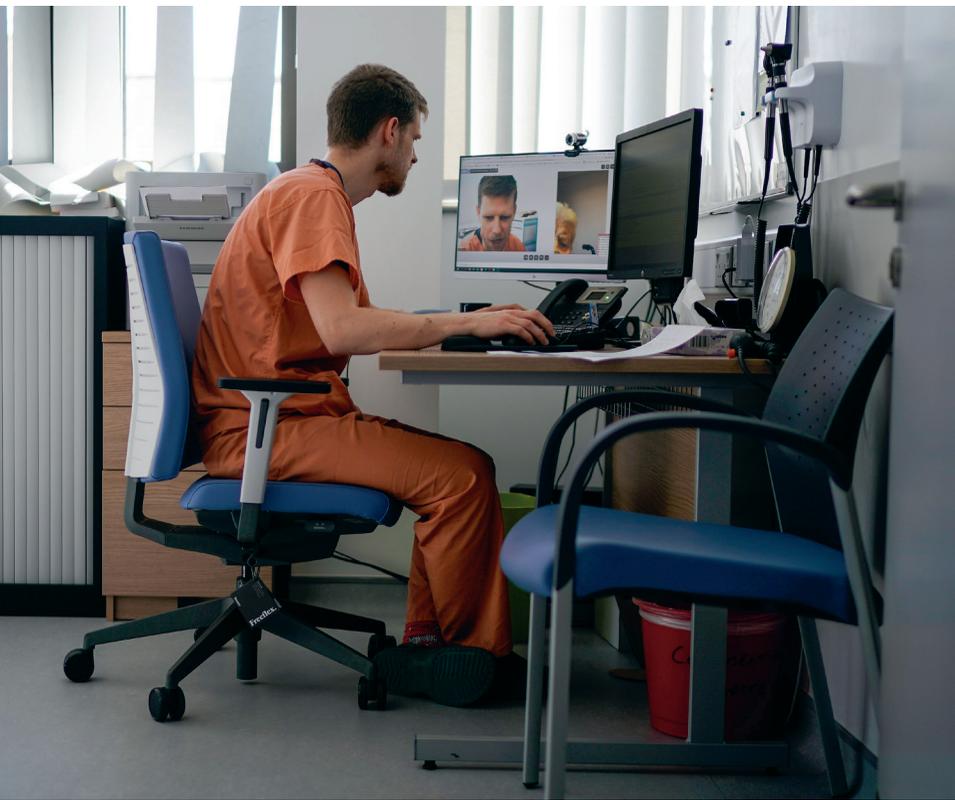
## E-prescriptions have become the norm

cope with fast changing and complex problems. Of course, as with any new systems there were reports of teething troubles; but with the dedicated and wonderful professionals that we have working in the health service – and because there were no alternatives – these became molehills to be crushed rather than mountains to halt progress.

For the NHS coronavirus has meant innovation. In practices up and down the country GPs were printing and signing prescriptions as recently as six months ago; now e-prescribing has become the norm. And while the concept of digital interaction between doctor and patient has become the public facing reality of the pandemic, digital within the service has very much come to the forefront too.

In many ways Covid-19 has become the trigger to remove antiquated processes. In some cases, for the first time we are transmitting notes and letters electronically. Who knows? The NHS may even move away from holding that unenvied label of having been the world's largest purchaser of fax machines.

We should never lose sight of the fact



opportunities to streamline management and opportunities to get rid of red tape. Since its inception the NHS has innovated in clinical excellence, while arguably it has lagged in its administrative processes. The pandemic has challenged that way of thinking.

I would very much hope that tangible outcomes would be better digital connections between primary and secondary care to allow easier sharing of notes and letters; flexible working for those on the front line and technical support to continue the trend; better integration between health professionals in multidisciplinary teams; and to strengthen the important relationships between the NHS and care homes. All of the above exist, but the virus has shone a light on these areas to show they have huge potential to help the NHS move forward.

Finally, with the drastic change in the interface between patients and healthcare workers, there is a danger that the professions retain this positivity, but the public is left behind.

Constituents have contacted me to tell me that they can't see a GP, but when asking further it transpires they can, but the clinician is working in a different way and able to manage the workflow in a new manner.

It is vitally important that together we educate our users into understanding that as delivery changes, our focus on the patient never does. As policymakers it is our duty to educate the public about the changes in interaction with health providers and what the benefits are in the service being provided. But we must highlight the opportunities this offers: to see more patients, to signpost care more clearly, and to give a better ability for clinicians to manage their workload.

I am mindful of the words of Henry Ford when he said: "If you always do what you've always done, you'll always get what you've always got." Covid-19 has meant that we don't always have to do what we've always done, and where the outcomes of innovation are better it has made us realise that we can embrace them. ●



the medic's own family circumstances. Such an open-minded approach may well help to retain some of the doctors who had left their role but came back in response to the nation's call.

All of this innovation has in-built potential for improved health outcomes too. Sitting on the Health and Social Care Select Committee we heard how cancer specialists working together have been able to build and model new clinical pathways. In a culture saying yes to innovation, in many ways for the first time, collaborative working has become fluid and doctors encouraged to be fleet of foot in addressing challenges.

Covid-19 has been responsible for a great loss of human life. We cannot let the price we have paid be forgotten. Politicians and policymakers must step up to help the NHS, we must be clear in our role so that the health service's greatest resource – its staff – can do theirs.

We are in a moment when there is a real opportunity to create a positive legacy from coronavirus. The positives that have come out of this period of history must be retained, they give us great opportunity –

that the NHS is an employer too. As we have seen the benefits of home-working throughout the pandemic, with work-life balance for those working from home improving and the potential to realise office savings for employers, there is a real scope for NHS staff to do the same.

A GP working from home and adopting telemedicine principles has the capacity to provide every bit as good a service to patients as being desk based in a surgery, while at the same time reducing levels of burnout and potentially complementing

# The lessons to be learned from Covid-19

The unique challenges of the pandemic have created new public-private health partnerships, says **Dr Subashini M**, associate medical director at Aviva UK Health and Protection



**I**t has been nine months since healthcare systems around the world had to implement their pandemic planning paper-exercise in real life against Covid-19. In the UK, the government introduced a series of measures to manage the pandemic, including private facilities agreeing to reallocate much of their national capacity to support the NHS and help to meet the anticipated demand for clinical care.

The pandemic put significant pressure on our NHS, but it coped the best it could. Non-urgent, non-Covid-19-related services were deprioritised to ensure that healthcare resources were pointed at the greatest public health challenge of this century. While initially this approach gave us comfort, concern grew when the public learned that many private beds remained empty during this time, with questions around why they couldn't be used to support patients whose cancer diagnostics and treatments had been delayed. It is a

perfectly reasonable question, and one which I can empathise with.

As a patient, we only see the care we get access to. A bed isn't just a physical entity – it comes with a whole support team including HCAs, porters, doctors, nurses, laboratory technicians, drugs and critical care support. When it comes to conditions such as cancer, whether it is chemotherapy, surgery or diagnostics, everything must be lined up perfectly to enable the procedure to take place safely. Cancer treatment is a precise art requiring meticulous planning. There is no room for error. Just one missing piece of the “recipe” can severely compromise patient safety.

This is crucial, as one of the key pillars of medical ethics is non-maleficence – do no harm. This ethos underpins all clinical decisions and this pandemic has added complexity to this decision-making process. Duty of care in this situation is not limited to the patient but also to healthcare staff.

Throughout the initial peak of the

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pandemic, healthcare teams have faced challenges – from the availability of PPE to assessing whether it was fit for purpose, from the accuracy of Covid-19 testing kits to the availability of lab staff to process the results. At times, access to essential drugs and critical care staff was also limited. Where these issues were overcome, healthcare teams have had to make extremely difficult decisions regarding which patients to prioritise.

There is no getting away from the human impact of the Covid-19 pandemic. Tragically, there will be those who will see their life cut short. It is an awful situation, brought about by devastating circumstances. The scars of succumbing to or surviving the pandemic cannot be underestimated and plenty remains unknown.

Now that the initial peak of the pandemic has passed, the NHS has started to restore some of its other services on a localised basis, and the nationwide contract between

the NHS and independent sector providers has also been scaled back. While a proportion of private sector resource is still available to support the NHS during this time, many facilities have introduced measures such as extending opening times (including at weekends) to enable them to see patients expediently.

Throughout the pandemic, private medical insurance providers took a united stance through the Association of British Insurers (ABI) to support the response to the national challenge. In conjunction with the Independent Healthcare Providers Network and ABI, new processes and practices were introduced to help private medical insurance customers during this uncertain period. Private hospitals share weekly situation reports which help insurers to identify the services that are available and which consultants can see our customers.

At Aviva, we feed this information directly into our front-line systems so that our claims teams can help support and guide customers to relevant treatment providers, booking appointments for them where the functionality is available.

Our number one priority is customer safety. Through our “Aviva Assurance” process, we capture each provider’s Covid-19 operational processes to assure ourselves that appropriate protocols are being followed to provide treatment in a safe environment. We also fund a PCR test for customers who are about to undergo private medical treatment to test whether they have the virus, in order to protect them,

## Covid-19 has brought the health sector together

other patients and healthcare workers.

Our claims data for the past few months saw suppliers successfully adapting to the situation. As expected, and in line with national guidelines, surgical treatments for non-urgent conditions such as orthopaedics dropped significantly during the peak of the pandemic.

However, claims for outpatient consultations and treatment remained buoyant as healthcare professionals adapted to providing care through video or telephone consultations. We also saw cancer services being reconfigured to offer care at home where appropriate and private hospitals repurposing areas within the hospital to help them to continue treating patients in a safe manner.

The pandemic has changed the face of both public and private healthcare forever. Covid-19 has brought with it new challenges. We are already hearing about increasing levels of mental health conditions – reflected by our experience of customer claims. Patients who have had Covid-19 are reporting a range of lingering post-viral fatigue, neurological, cardiac and respiratory symptoms.

As the health industry navigates its way through the situation, there will be opportunities to take stock and learn from the experience. We have seen digital healthcare adopted at a pace, triage processes introduced to ensure that valuable resource is focused on those most in need, and a more personalised approach to healthcare. We have also seen the UK’s obesity challenge move up the government’s public health agenda. By tackling obesity, the nation will see a positive impact on other conditions such as diabetes, heart disease and some cancers.

We are proud of the way that the whole healthcare industry has come together to face Covid-19 head on. All of us have adapted, pulled together and learnt valuable lessons from the experience, and my hope is that we put this knowledge to use to rebuild a more resilient, healthy and fair society. ●

Tackling poverty and inequality will help the pandemic response, says **Jeanelle de Gruchy**, president of the Association of Directors of Public Health. Interview by Samir Jeraj

# Why coronavirus is more than a public health crisis

**W**hen Jeanelle de Gruchy began her career in medicine 30 years ago, the Aids pandemic had gripped her home country of South Africa. She worked as a clinician in a rural area of Eastern Cape as the country emerged from Apartheid. While there was political equality between black and white people, the social and economic legacy of more than 40 years of enforced segregation had left a visible and toxic legacy. “Poverty and its impact on some of the most vulnerable people in society is just devastating,” she told me recently via Zoom.

Now, de Gruchy is at the forefront of tackling Covid-19 in the UK as president of the Association of Directors of Public Health (ADPH). These are the public servants in local government in charge of everything from infection control to encouraging healthy eating and exercise. She combines this role with her job as director of public health at Tameside Council, which borders Manchester.

In 2016, the health and social care services previously divided between the NHS and local government were devolved to Greater Manchester in an effort to integrate them and provide a better service. The value of joining

forces when it comes to care has never been clearer to de Gruchy than in the pandemic response. With “something like Covid-19 you need all parts of the system to be working really well,” she explains.

When we spoke, Tameside was one of the boroughs with a local lockdown, with household mixing restricted, among other measures. De Gruchy stresses the importance of cooperation between local government and Public Health England. “The CMO [chief medical officer] right from the early days, contacted us, and myself as president, and said [he was] ‘really keen to have close dialogue with the directors of public health in local areas’.”

There were tensions, however, particularly over Westminster-led policy. “There was a lot of designing policy

nationally without really appreciating or understanding that local knowledge and expertise that was already there,” she says. “If you design things nationally and in silos, somebody in a local place has to knit them together.”

But there has been progress: data is being shared, there is greater flexibility in local testing, and public health teams are more integrated into the national test and trace programme.

Austerity has been a major challenge – both its direct impact on services, and on jobs, housing and welfare. The public health grant received by councils from central government has been cut by £850m since 2015, according to a 2019 study by The King’s Fund. “Our capacity has been cut,” she says, “I know that from my personal experience of good staff that aren’t there anymore.”

One of the less tangible effects of austerity has been the erosion of trust in government and public services. De Gruchy remembers how a cocktail of poverty, discrimination, stigma and conspiracy theories, including from those in positions of authority, weakened the fight against HIV. “The consequence of all of that... is a lot more people get infected, a lot

**“Racism is bad for society’s overall health”**



more people die,” de Gruchy says.

Apartheid and its legacy are a key influence on de Gruchy’s approach to healthcare. “Inequality, racism or any forms of discrimination is really, really bad for your health. And it’s really bad for your society. And everyone suffers as a consequence,” she says.

When de Gruchy became ADPH president two years ago, one of her main objectives was to make discrimination and inequality visible, because, she says, “you need social justice for a healthy population”. In South Africa inequality and prejudice were obvious because they were the law under Apartheid, but in the UK she thinks it is harder for people to see how discrimination operates.

And that is often in the most innocuous of ways. De Gruchy recalls going to a presentation about pensions as an NHS employee in the late Nineties, where she was informed that straight, married couples could depend on the system to support them in the event of the death of their partner. When she asked about her status as an unmarried lesbian with a partner she was told not to expect anything. The situation has now thankfully changed. “It’s so banal and yet, that’s how it works. And it’s this



massive, ridiculous difference.”

She calls this the “hidden hegemony of what’s normal”, and in order to change it de Gruchy believes we need to ask the “uncomfortable” questions that disrupt what many people consider the “everyday lovely English life”. But she also wants to affect attitudes to the wider determinants of health. If a government just puts money into hospitals, then it is missing opportunities to make sure people do not get sick in the first place. The NHS is “amazing”, she says, but there needs to be more focus on prevention and public health, particularly factors like better housing

and jobs. She is hopeful this crisis will open people’s eyes.

But looking to the future and the likelihood that winter will bring a rising R-rate, de Gruchy believes that those living in poor housing and working lower-paid jobs will be worst hit. She calls for some “immediacy” in improving those conditions; she does not want a return to a normal where a blind eye is turned to inequalities. Insecure jobs, structural discrimination and underfunded social care all contributed to the UK’s poor response to the pandemic. “What’s the post-Covid vision?” she asks.

Days after we spoke the government announced that Public Health England (PHE) would be abolished and replaced, at least in part, by a National Institute of Health Protection. There is little information about where all of the work PHE did on the wider determinants of health, like housing and work, will go.

In the aftermath of the decision, de Gruchy stated that dismantling a national public health agency in the middle of a pandemic was “a bold move”, and that setting up a new one as a second wave approaches “presents a significant risk”. ●

# A healthier and more resilient future

The life sciences can be the foundation of a strong economy and society, says **Ben Osborn**, UK country manager at Pfizer

**A**t the start of this year, few people would have disputed the value of the NHS to our nation. But its importance in every aspect of our lives – not just to our health, but to our jobs, our businesses, our schools and beyond – has rarely been as clear as it is today. Right now, we can feel proud that our world-leading national health service has coped at a time of almost unimaginable crisis. Stories of heroic frontline staff and patient testimonials have shone a light on its ability to provide high quality, sustained emergency care in even the toughest of conditions.

But these impressive efforts are designed for a sprint, not a marathon. In the long term, we risk a widening health inequality across many disease areas, as well as putting unsustainable pressure on our doctors and nurses. Which is why we must act now to build a healthier and more resilient Britain for the future, in which every individual in our society plays a role.

Put simply, it's time to build a mindset

and health system that keeps people well, not just makes them better. The aptly named new National Institute for Health Protection has recognised that protecting our nation's health – and health system – is a top priority if we are to better equip ourselves against Covid-19.

But the government also needs to re-prioritise health as one our nation's greatest assets – and empower our population to do the same. The link between the health of our nation and the health of our economy is clear to see and across government ambition must now shape policy and lead change that recognises the far-reaching impact of health.

Covid-19 has exposed the deep links between our health and the economy. Ill health reduces the UK's workforce earning capacity and costs the NHS in treatment. Healthy people earn a consistent wage, have the capacity to spend more, and require fewer medical interventions or treatment – not to mention the impact on mental health and wellbeing.

This is clear when we look at the impact of specific conditions. Musculoskeletal problems, like arthritis and back pain, are the cause of 30 million working days lost each year, amounting to £2.5bn in lost productivity.<sup>i</sup> A recent report, commissioned by Pfizer, found that cancer costs the UK £7.6bn a year in lost wages, benefit payments and mortality, with a third of patients losing income following diagnosis.<sup>ii</sup> And a hefty £71bn – equivalent to a third of NHSE's budget – is spent every year by the government on mitigating the impacts of illness through covering costs such as disability or social care support.<sup>iii</sup>

The right approach could empower patients and protect the NHS. Recent events have prompted progress. Coronavirus has shown that, in this crisis, we are more willing to take responsibility for our own health – and to adopt new ways of doing so. It has also accelerated innovation in the delivery of healthcare.

We have seen significant growth in

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patients accessing primary healthcare remotely, at home – reducing the spread of infection and keeping the vulnerable out of hospital, while maintaining access to vital medical expertise and treatment.

We need to capture practical and behavioural gains, such as these, to deliver long-term benefit that goes way beyond a short-term fix. Of course, the right treatment, for the right patient, in the right place should always be the goal. But if we get it right, just imagine a future where patients needing traditional in-patient care, such as chemotherapy, can receive elements of their treatment safely and comfortably at home. We're not there yet, but it is a vision that is not as far away as it may sound. The benefits for patients are clear – but for the wider system, a more efficient, established home care system will ensure hospitals have more resources and capacity to treat those that do need to be in a clinical setting.

The global race is well upon us now as governments around the world seek to attract investment from life science companies. The UK has the opportunity to be at the forefront of this if we can accelerate the pace with which science, data and technology are coming together, put research at the heart of clinical practice and recognise the value of innovation to our society.

Coronavirus has highlighted that lots of us are living with underlying health conditions, while one in five deaths in the UK, even before the pandemic, was considered “avoidable”.<sup>iv</sup> A focus on prevention can help to address these issues, while also alleviating the annual “winter pressures” of ill health.

## Keeping people well should be a policy priority

The UK is a world leader in childhood immunisation, but there are other vaccines available that can help keep people healthy at every stage of life. Many of the UK's most vulnerable adults are eligible for a range of vaccinations against infectious diseases – from pneumonia<sup>v</sup>, to shingles and whooping cough. But uptake falls far below what it could be. In the last year in England, just one in ten (12.9 per cent) of 65-year-olds were immunised against pneumonia. For younger people in “at risk” groups, uptake rates were as low as one in four for patients with illnesses such as chronic liver disease.<sup>vi</sup> And while those over 70 are eligible for vaccination against shingles, by the age of 76, around one in four are still unvaccinated.<sup>vii</sup> Even in the case of flu, many of those who were eligible last year failed to get vaccinated, including less than half of those in “higher risk” groups, from people with an existing health condition to pregnant women.<sup>viii</sup>

By encouraging more people to take advantage of the vaccines they are eligible for, we can help protect millions of people and ensure our health system is better equipped to deal with a potential second wave of Covid-19. But we shouldn't stop here. Vaccination is just one example where a greater emphasis on prevention could reap significant rewards for our national health and resilience. There are many other areas in which we can make significant strides towards keeping people well, such as in smoking, where there are still untapped opportunities to support the UK's seven million smokers in giving up. With “Stoptober” just around the corner, a public health push to help more smokers than ever before to quit for good could make a significant difference to our nation's health.

Such measures will help prevent ill health. But to truly reappraise and rebuild our way of thinking, we should consider creating a new Health Index that puts health on a par with our GDP. In doing so, we can capture the return on investment to the economy from expenditure on health – in turn, helping

us to make good health a matter of national priority.

My industry has a key role to play and as we have shown throughout this crisis, our focus on human health and bringing breakthroughs to change patients' lives is our singular purpose: but radical collaboration between businesses, charities, the NHS and wider government – as well as UK citizens – is now needed. It is time to work together, not only to make people better today, but to keep all of Britain “well” long into the future. ●

Please note, these reference links are provided for convenience, but Pfizer does not guarantee/own the content unless otherwise specified.

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The government, with its £100bn “moonshot” testing programme, hopes Covid-19 certification can reopen society. By **Oscar Williams**

# The rise and fall of the immunity passport

In late March, Gérard Krause – a German epidemiologist – was preparing to launch one of the largest antibody surveys in Europe. The 100,000-person study was designed to assess how many people in Germany might have already developed a level of immunity to Covid-19.

The research attracted widespread media attention, and Krause gave one of his first interviews to the news magazine *Der Spiegel*. A brief quote from the Brunswick-based scientist appeared at the end of a 300-word news story outlining his study. “[Those who have antibodies] could be issued with a kind of vaccination certificate that would allow them, for example, to be exempt from restrictions on their work,” said Krause, in remarks that have been translated from German.

Only a few days after the article was published, stories started appearing in English-language media that claimed Germany was planning to issue thousands of certificates that would allow people to escape lockdown restrictions. But the reports were based on a misinterpretation of what Krause had said, the epidemiologist told *Spotlight* earlier this month. Rather

than revealing that Germany planned to push ahead with this particular idea, Krause was only describing what might be possible.

Nevertheless, the concept of the coronavirus immunity passport had been released into the world, and, like the virus it was supposed to defend against, it spread fast.

In the UK, less than a week after Krause’s remarks were published, the Health Secretary Matt Hancock announced at a daily press briefing that the British government was “looking at the possibility” of launching its own immunity passport scheme.

While the World Health Organisation (WHO) warned against the adoption of such schemes in April, noting that “there is currently no evidence that people who

have recovered from Covid-19 and have antibodies are protected from a second infection”, the government continued to explore the idea.

In June, the Centre for Data Ethics and Innovation, a government advisory body, said immunity passports could “prove valuable” in the months ahead. In a blogpost, it admitted that scientists must first prove that the presence of antibodies guarantees immunity, while acknowledging that immunity passports could incentivise people to contract Covid-19.

But, despite these concerns, the CDEI concluded: “Although there are risks inherent to immunity certificates, there are few tangible alternatives, and any that do develop will likely hold similar trade-offs and concerns.”

Commenting on the CDEI’s report at the time, Michael Veale, a lecturer in digital rights at University College London, said it “barely even touches upon the questions of what [the immunity passports] would be used for, who would be able to ask for them, what they should or should not have access to, [or] who would be able to challenge provision or non-provision of one.”

**“Antibody levels fall after three months”**



The government's £100bn "moonshot" testing plans were met with scepticism

When pubs reopened in England on 4 July, the government had stopped talking publicly about immunity passports altogether. Although it had reportedly discussed with tech firms how such a scheme could be rolled out in Britain, Whitehall's appetite for the certification had seemingly diminished.

It wasn't just in London, however, that the momentum was slowing. In May the entrepreneurs behind the tech start-ups Bolt and Transferwise had unveiled plans for an immunity passport trial in Estonia, a famously pro-tech nation. But it failed to take off; one source with knowledge of the project told *Spotlight* that, as the level of Covid-19 cases plummeted in the Baltic state, so too did the number of trial participants.

Even in Germany, where the coalition government has expressed tentative support for the idea in recent weeks, there

is still reticence about moving forward until more is known about Covid-19 immunity.

A study from King's College London in July revealed antibody counts in people who recover from the disease tend to fall sharply three months after infection. Plans for certification were further complicated by Swedish research indicating that roughly twice as many people who have antibodies may have a degree of immunity through T-cells, which are significantly harder and more expensive to detect.

In the UK, the government has signalled it is now moving in a different direction. Earlier this month, while detailing plans to make gatherings of more than six people illegal, Boris Johnson announced a new "moonshot" project that would enable people to secure rapid Covid-19 tests to prove

they aren't suffering from the virus.

The Prime Minister said that "in the near future", the testing would "identify people who are negative – who don't have coronavirus and who are not infectious – so we can allow them to behave in a more normal way, in the knowledge they cannot infect anyone else... We believe that new types of test, which are simple, quick and scalable, will become available. They use swabs or saliva and can turn round results in 90 or even 20 minutes."

But memos leaked to the *British Medical Journal* revealed that the plan, which would involve millions of daily tests, could cost £100bn: roughly as much as the government spends on education each year. Bottlenecks in the existing testing programme have also cast doubt on the credibility of the plans. But there is an even more fundamental issue: the technology underpinning the plan doesn't yet exist.

"The Prime Minister's suggestion that this will be as simple as 'getting a pregnancy test' that will give results within 15 minutes is unlikely, if not impossible, in the timescale he was suggesting to get the country back on track," Dr David Strain, the chairman of the British Medical Association's medical academic staff committee, told the BBC.

If, as a number of scientists have predicted, the moonshot project fails, it's not difficult to imagine a resurgence of support for immunity passports, which would provide the same kind of freedoms Johnson envisages for people who test negative under his latest scheme.

As "new ideas" to tackle Covid-19 have emerged over recent weeks, Gérard Krause acknowledges that support for his idea has ebbed. "But the concept is something that I, of course, stand behind."

While he admits there are "legitimate" concerns about encouraging infection, he reveals he is working with ethicists and biologists to "elaborate" on the proposals. "I've not yet decided whether or not we should promote the concept, but it's too early to discard it." ●



In Britain in the 1960s, access to the polio vaccination was expanded from people up to the age of 26 to up to 40 years old



# Why a vaccine is only the start

*Samir Jeraj*

**L**ast week, the Covid-19 vaccine trial run by the University of Oxford and pharmaceutical firm AstraZeneca was halted after one of the test subjects fell ill. It was a setback for one of a number of vaccines under development across the world.

The UK, with a population of 66 million, has already ordered 250 million doses of four potential vaccines. Several manufacturers have plans to provide up to nine billion doses by the end of 2021, reports consulting firm McKinsey. The global population is currently 7.7 billion. But while the focus has been on who gets there first, there has been less attention on what happens next. How do you get a vaccine to everyone?

In the UK, the scrapping of Public Health England (PHE), the body which ran national immunisation programmes and health promotion campaigns, could be a big challenge. The new National Institute for Health Protection, which PHE is to be partially replaced by, is likely to carry on these responsibilities, but there has been little detailed information to date. Even if it does, institutional change is difficult at the best of times, let alone during a major health crisis.

How a Covid-19 vaccine is delivered to over 66 million adults and children needs careful planning. While schools could vaccinate the young, the nearest thing to a population-level immunisation programme among adults in the UK is the free seasonal flu shot, available to 25 million people.

The indications are that a Covid-19 vaccine will probably require two or more

doses. People who move around a lot or who are unable to prioritise their health will be less likely to get both. Vaccination may also need an annual refresh – replicating the challenge yearly.

Certainly at first, it is unlikely that there will be enough vaccines to immunise everyone at the same time. Specific groups – the elderly, key workers, and people with long-term conditions – will need to be prioritised. It is also possible that more than one vaccine will be licenced at once. It will be important to track who has had which vaccine in order to monitor its effectiveness.

A significant number of people will likely be resistant or reluctant to getting vaccinated. Broader trust in the healthcare system is a challenge for marginalised groups most at risk from Covid-19, too. Black and minority ethnic and migrant communities often have good reasons to distrust health services, including fears of information on immigration status being shared with the Home Office.

But there is also the knock-on effect of a mass-immunisation programme. Turning over factory production to Covid-19 vaccines could mean a shortage of treatments or vaccines for other illnesses and losing ground in the fight against childhood diseases in particular. “We don’t want to throw out the very highly effective and well-established childhood-immunisation programme in return for a Covid vaccine,” says Professor Beate Kampmann, director of the Vaccine Centre at the London School of Hygiene and Tropical Medicine, “we wouldn’t be doing ourselves any favours.” ●

# Creating a positive Covid-19 legacy

The pandemic has injected fresh and welcome urgency into public health policy, says **Hugo Breda**, managing director at Johnson & Johnson Medical Devices UK & Ireland



**T**hroughout history, we often see that the most tumultuous periods bring with them the brightest moments of innovation. In healthcare that is certainly true. It was world wars that led to the invention of the orthopaedic splint, the widespread development of antibiotics and even played a part in the formation of the NHS itself.

As we continue to grapple with the “new normal” in a Covid-19 world, amidst the daily updates on positive cases, loss of life and the impact on economies across the globe, it can be hard to focus on positives. There is no denying the devastating ongoing impact of the pandemic, but I would urge the government and healthcare sector to take a step back to focus on the opportunities before us and certain challenges that, if we don’t tackle them now, will continue to place a strain on patients and our NHS for generations to come.

As the government, NHS and

industry seek to reform the way healthcare is delivered, particularly when considering the role of the newly created Institute for Health Protection, we need to look at the entire patient journey from prevention through to treatment and follow-up. This must include tackling how services are delivered to vulnerable groups of patients to even out the inequalities in the healthcare system that the pandemic has highlighted, such as in age, gender, ethnicity and socio-economic deprivation.

## Healthcare must be preventive, not reactive

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For me, one of the key questions is how do we prevent, or more efficiently treat diseases that increase the burden on the NHS, drive costs and put patients' lives at risk in the first place?

### **An opportunity to tackle obesity**

One of the biggest population health challenges that has been identified as paramount to the pandemic is obesity, and its implications in the severity of coronavirus illness. I was pleased to see the recent government announcement about a range of new measures being introduced as part of its new obesity strategy; however, obesity is not a new challenge in the UK – with almost two-thirds (63 per cent) of adults in England being overweight or living with obesity and obesity-related illnesses, costing the NHS £6bn a year.

The urgency of tackling obesity has certainly been brought to the fore by evidence of the link to an increased risk from Covid-19. I believe it is now the duty of the government, industry

and healthcare practitioners to seize the opportunity this brings and drive meaningful, lasting change. We need to collaborate to identify and implement a “whole-systems approach” to successfully challenge obesity – one that looks at prevention right through to treatment, including surgical intervention.

Being one of the world's largest healthcare and medical devices companies, we also see the impact obesity puts on other services. Obesity is a gateway condition to 400 other illnesses and co-morbidities and increases the risk of 14 different types of cancer. The strain it puts on patients' joints means a greater demand on orthopaedic services; the increased risk of having obesity brings with it increased risk of cardiovascular disease, diabetes, stroke and cancers – all specialties adversely impacted by Covid-19 that are now grappling with huge waiting-list challenges or influxes of patients with advanced-stage diseases who were too afraid or unable to access treatment sooner.

### **Reforming and redesigning services**

At Johnson & Johnson Medical Devices we are now supporting many of these specialties with service redesign to help them tackle the backlog in the short term, but also make lasting reform to be more efficient and safely treat more patients in the long run. We have developed a range of recovery packages and digital solutions based on listening to the changing needs of NHS Trusts and Sustainable Transformation Partnerships (STPs) so we can co-create value-based services and solutions together. This has enabled us to forge many new partnerships with the NHS – helping it to understand and create efficiencies within its systems with the ultimate aim of improving outcomes for its patients.

We are also collaborating to maximise best practice aligned to GIRFT (Getting it Right First Time), tailoring bespoke solutions based on a trust's needs to introduce and streamline everything

from product utilisation and digital tools, through to theatre utilisation, patient engagement, and resource management tools that help to unlock capacity, free up resources and help the millions of patients who need treatment.

While the pandemic has undoubtedly put one of the biggest strains on services the NHS has seen, it has shown how, when truly needed, it can be agile and quickly reform, serving multiple archetypes. From our work, it is clear that empowering trusts across the country to do things differently can create lasting, positive change.

I believe this gives the NHS its best ever chance of beating the traditional winter pressures, and managing a second Covid-19 wave of hospital admissions while maintaining other speciality services.

### **Looking to the future**

But I believe these learnings also bring a new opportunity to change the way we treat population health more broadly – as resources continue to be pumped into the NHS, it would be a huge waste not to capitalise on this now. As we collaborate to reform services, we must also focus resources more broadly on the prevention of disease in the first place through education and pathways, promoting healthy lifestyle choices, and measures that will have a positive impact on prolonging life among the population as a whole.

This devastating pandemic could in fact be a watershed moment in creating the social and political motivation to reform existing services for the long term and build a system that values everyone's health equally – placing as much emphasis on the prevention of disease, just as much as treating those who are sick.

What an achievement to be able to reflect back on when we remember the early 2020s – yes, it was the era of Covid-19, but it was also the period in time that saw meaningful change in tackling some of our biggest health challenges of the 21st century. ●

**Pubs and offices may have reopened, but in some NHS trusts pandemic restrictions on maternity wards were still in place this month. By [Alona Ferber](#)**

# Labouring alone

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**I**n June, when lockdown constraints were starting to ease – the reopening of shops and zoos, the introduction of social “bubbles” – Ruth, 29 and pregnant with her second child, went to Peterborough City Hospital in labour.

Although society was tentatively opening up, the hospital was sticking to strict coronavirus rules. At first, she was in labour alone, her husband waiting outside the door of the ward. Birth partners were only allowed in during more advanced stages of labour.

Ruth’s husband was allowed in some 20 minutes before their daughter was born at 6.40am that Friday morning. By 11am, he was asked to leave. Like a number of hospitals in the UK, no visitors – not even birth partners – were allowed on the postnatal ward.

Not long after Ruth’s husband left, her baby began struggling to breathe: chest pulled in, nostrils flaring. Staff put the newborn on antibiotics, so Ruth stayed on the ward for another two days. She didn’t see any family or friends, not her husband or two-year-old daughter, until she left on Sunday evening.

“At night it was probably the worst,” she told me over the phone. “We were on a ward of, like, four babies that all woke up at different points, and because she had breathing difficulties and they were worried about her, I found it really hard to sleep. If I had my husband there just to take her for half an hour, I could have slept. When we had our first he obviously stayed all the time.”

Across the UK, as the months of lockdown dragged, pregnant women and their families were met with an anxiety-inducing postcode lottery of changes to maternity care. With each trust using its own interpretation of national guidelines from the NHS, Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG), restrictions varied.

Women were limited to one birth partner. There were limits on accompanying women during labour and some places cut access to services such as home births.

Like much of the NHS, many trusts

used virtual appointments for some antenatal care.

In the worst cases, says Maria Booker, the director of the charity Birthrights, these rules remained what they were at the height of the pandemic: partners kept out until “established labour”, prohibited from staying after birth, and not allowed to antenatal scans.

Women have gone unaccompanied for inductions and to pre-C-section operation prep. They have also had to receive bad news on their own.

Recovering alone from a “smooth” birth is hard enough, but it is even worse after a traumatic one – all the while dealing with staff who are under pressure in a pandemic and wearing full PPE.

Even though the government had been urging people to “Eat Out to Help Out” all August, some trusts were still not allowing visitors on to wards or at antenatal scans as late as this month.

NHS England only issued guidance to encourage trusts to “reintroduce access for partners, visitors and other supporters of pregnant women” on 8 September. The move followed calls for guidelines from charities like Birthrights. The charity said England was lagging behind the devolved nations, where there was political direction to remove restrictions from June or July.

The #ButNotMaternity campaign, and a 343,000-signature strong petition (at the time of writing) to the Health Secretary Matt Hancock and the NHS, added to the public pressure.

On the day the new guidance was published, the RCM and RCOG released a statement criticising NHS England for the delay, saying it was “dragging its feet”.

The CEO of RCM, Gill Walton, said: “The RCM and RCOG worked

## Women have received bad news alone

together to support NHS England to complete draft guidance in early August, yet here we are, over a month on, with still no publication.”

Now, as Boris Johnson once again tightens Covid-19 measures, and with local lockdowns looking likely, there are concerns that lessons won’t be learned from this mass experiment in maternity service provision during a crisis.

In 2015, a National Maternity Review led by the Conservative peer Julia Cumberlege resulted in the Better Births policy, now in its fifth year, which sets a vision for maternity services across England to become “safer and more personalised”. The Morecambe Bay Investigation, concluded that year, found that serious failures of care at Furness General Hospital led to the deaths of 11 babies and one mother.

Soo Downe, a midwife and professor in midwifery studies at the University of Central Lancashire, is leading an ESRC-funded study to find out how these two strands were safeguarded during the pandemic.

“The idea is to look at a range of different hospitals, hospital trusts, and community services to say: what was the most effective way of responding to the crisis to ensure safety and personalisation so that women got choices?” she tells me.

Part of the study involves monitoring constant updates to maternity services by tracking changes on trust websites and on social media. It is clear that there has been a mixed response across the UK, she says.

Different trusts have restricted or permitted companions for women at antenatal scans, labour, birth and on postnatal and neonatal wards to varying degrees. In July some places were only allowing birth partners to visit for one specified hour each day, but many trusts had reinstated home birth. The study will be looking at the variation, and how it can be minimised in future.

It is also possible that some mothers and their families saw a positive side to these arrangements. Birte Harlev-Lam, executive director for Professional Leadership at the RCM told *Spotlight*

that “some of our members have found that breastfeeding rates have improved as a result of visiting restrictions, as women have had more time to work with midwives and maternity support workers. They’ve also noted how women have supported each other on postnatal wards. That’s not to diminish the role of partners.”

Outside of her study, Downe notes some examples of good practice. This includes Chelsea and Westminster Hospital NHS Foundation Trust, for its “very creative” use of private ambulances to keep home birth provision open, and a two-year-old continuity of care scheme in Warwick, which may have helped the hospital to minimise closing services.

The NHS did not respond to *Spotlight’s* requests for data on how many trusts have been imposing which restrictions.

“I think women are feeling really frustrated and starting to get cross and anxious about why their needs aren’t being prioritised,” says Booker. “The issue is that it has been left to the discretion of trusts, and they are taking a different view of it.”

In some hospitals, midwifery units may have felt restricted by wider trust policy and restoring visitor access might not have been a priority; for some it might even have made things easier.

“Trusts can’t reduce the amount of women they see,” Booker says. “Some do genuinely have issues with their estates [when it comes to social distancing], but have they looked at all possible solutions?”

Between June and August, Birthrights received a growing rate of queries to its advice line from people worried about restrictions. The charity has also picked up concern about postnatal care being cut, with an increase in virtual meetings. The worry is that temporary changes will become the norm.

What has been made clear is that birth partners are not mere visitors, and shouldn’t be treated as dispensable. Why have women have been allowed to go to the pub, but not allowed to have a partner with them on the ward? “Partners



have a real stake in the care of their baby,” says Booker.

The restriction on companionship for antenatal scans is particularly distressing for parents who have previously lost a baby, says Clea Harmer, the chief executive of Sands, a stillbirth and neonatal death charity. According to Sands, one in four pregnancies ends in miscarriage, and in the UK every day 14 babies are stillborn or die within 28 days of being born.

The stress of attending scans and appointments alone has been the main issue Harmer has found among bereaved parents during the pandemic.

“It is devastating to receive the news that your baby has died in any circumstance, but to be on your own and without a partner is not something that we should be putting any mother through,” she says.

This highly sensitive area of care has been hard for both families and healthcare professionals during the pandemic. Aside from problematic social distancing protocols, Harmer also highlights the challenge of providing compassionate care while in full PPE, the closing of bereavement suites – where parents whose child have died are able to spend time and make memories with

their baby – because of Covid-19 restrictions, and the redeployment of some specialised staff.

“That’s been really challenging for those healthcare professionals left in positions of providing care but they haven’t yet had the training,” says Harmer.

She also worries that the government’s “stay at home” messaging puts women at risk, as some parents had been taking it very literally, even when they were worried about fetal movements or a newborn’s health. When Sands raised this – because parents were flagging it as an issue on the charity’s helpline – the NHS updated its messaging to encourage parents to come to hospital with concerns, says Harmer.

St George’s Hospital in London recorded a four-fold increase in stillbirths during the pandemic, though this has not been the case across the country.

The period since lockdown has taken a toll on the mental health of pregnant women and new mothers in general, according to research by the University of Liverpool and King’s College London. Preliminary findings from the first wave of their research, conducted from mid-April to mid-May and under review at a journal, “are quite shocking”, says the

University of Liverpool's Vicky Fallon.

Respondents to their online survey suggested a spike in clinically relevant depression and anxiety rates in new mothers were related to psychological changes as a result of social distancing measures. "The results are absolutely striking," she says. "We've never seen anything like it in all our years of research in this area."

Fallon and colleagues didn't specifically ask about maternity service restrictions, but the results highlight how vulnerable women and their families have been since lockdown.

Early on, the government advised pregnant women to shield at home, so many who gave birth in May or June had spent a long period of isolation.

Fallon says prenatal depression and anxiety affect things "as short-term as birth outcomes but as long-term as behavioural outcome in adolescence. In the postnatal period, we know that maternal mood has effects on social, emotional and behavioural outcomes in children."

Lauren, 30, from the Isle of Wight, has been taking anxiety medication since returning from hospital in May. After a traumatic birth – the baby was breech, and Lauren was rushed into an emergency C-section – she then spent two days alone in hospital, groggy from anaesthetic and hardly able to move after surgery. Her husband and daughter were not allowed to visit her.

"I hated being in there," she tells me. After 48 hours, "I was insisting that they let me go, even though not 48 hours earlier I'd had quite major surgery. I thought: if I stay, I'm just going to have a breakdown. I don't have anyone to help me."

When she got home, she had a panic attack. "I just don't think I really was able to process properly what had happened to me. I just got home and I thought you know, I just, I can't, I couldn't do it... So I ended up having to go on anxiety medication just to help get over the experience."

One senior NHS manager, who used to be a midwife herself, and prefers to

remain nameless, had her third child by elective caesarean this summer. "I think this is the biggest mishandling of the pandemic," she says. "It has not been women-focused."

She is particularly concerned about the impact restrictions have had on women undergoing caesareans, and says they have received less equitable treatment over this period than normal deliveries, because they had less time with partners.

"It gave me real anxiety," she says, "the idea that [her husband] wasn't going to see his son for two or three days" after the birth. She has written to the office of the Chief Midwifery Officer, Professor Jacqueline Dunkley-Bent, to the head of midwifery at her hospital, and to the patient safety minister Nadine Dorries to raise these concerns.

"We all want to see services return to as normal as possible, as soon as possible," says the RCM's Harlev-Lam. "Trusts don't make decisions to adapt services, such as restricting partners, lightly. They are making these decisions based on their local circumstances, such as transmission rates and the facilities they have available." Maternity staff were concerned regarding restrictions, she says, but "safe maternity care was not impacted and that's what is paramount".

Penny Snowden, deputy chief nurse for North West Anglia NHS Foundation Trust, which includes Peterborough City Hospital, said: "At the beginning of the pandemic the trust implemented visiting restrictions in line with national guidance to protect our patients, visitors and staff from the spread of Covid-19.

"We continuously reviewed this decision as the pandemic progressed and were one of the first trusts to allow partners to attend antenatal scans and

introduce structured visiting times, when we felt it was safe to do so. We understand the emotional distress that the restrictions caused women and their partners. Our staff have provided emotional support to women and their babies, but we know this isn't the same as having their partner with them during this time.

"The safety of our patients, visitors and staff has and continues to be our number one priority. We will continue to review restrictions and make adjustments where possible, while ensuring we can keep everyone safe."

Clea Harmer welcomes the 8 September guidance, but worries local implementation won't be swift to follow. "We... would urge hospitals to implement them on a local level as soon as possible, as we are hearing all too often of the distress it is causing to women not to be able to have their partners with them."

Meanwhile, for women like Ruth, the period following the trauma of birth, arriving straight after those long months at home during lockdown, has also been changed as a result of Covid-19.

"It just feels a lot like pregnant people and babies have almost been forgotten a little bit. There's stuff opening back up, now there's some local baby groups that opened up recently, but I've just felt quite missed really. I've been quite lonely this time."

An NHS spokesperson said: "The NHS continued to deliver safely 1,800 babies every day during the pandemic, and while it is understandable that the pandemic has caused expectant mums increased anxiety, the important changes to maternity services – backed by the Royal College of Midwives – were made to keep women and their families safe.

"Now we have moved past the peak of the pandemic and after extensive engagement with the various professional bodies involved, new guidance has been issued to all maternity units so partners can attend antenatal and postnatal clinics safely, in addition to attending labour which they have been able to do throughout the pandemic." ●

## "Anxiety is rising among new mothers"

# From chaos to catalyst

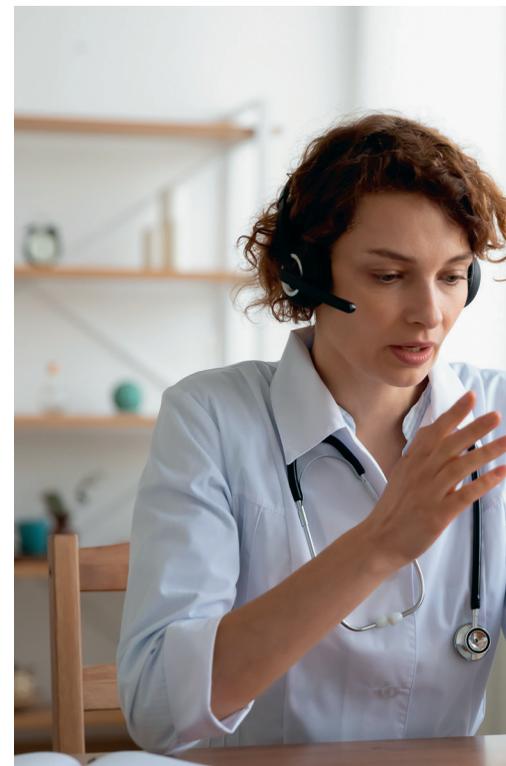
**William Shea** and **Sashi Padarthy**, vice president and associate vice president at Cognizant Healthcare Consulting, on five imperatives for the future of healthcare

**T**he coronavirus pandemic will be the catalyst for lasting change throughout the global healthcare industry including the UK. Key stakeholders – government, the medical profession, patients – need to work collaboratively to plan the right strategies to reimagine the future of healthcare in a world being reshaped by the pandemic. While no one truly knows what the long-term impact will be, we can make educated guesses, based on initial indicators. Around the world, the virus has forced healthcare organisations (of both the public and private variety) to adopt new ways of working, from wider adoption of telehealth to regulatory easing.

Meanwhile, patients are quickly adapting to new tools that support virtual and in-home care. Together, these forces are creating unparalleled opportunities for the healthcare industry, including the NHS, to address systemic inefficiencies and catch up with other industries regarding digital transformation. We recommend that healthcare organisations address the following five imperatives, adapting these to their business vision, local market conditions and financial strength.

## Take out costs

The financial effects of the steep drop in elective procedures have been widely calculated and reported and it is no surprise that health industry leaders are making changes to long-term investment plans. Optimising costs will be required to ensure business continuity. The NHS must consider the following:



- Benchmark operations, including revenue cycle, patient contact centres, and the supply chain against international peers to identify cost-savings opportunities.
- Consolidate and standardise clinical and non-clinical applications in the IT portfolio to reduce operating costs; retire or modernise legacy applications.
- Reduce costs by moving to the cloud. Cloud-based platforms put leading-edge technologies within reach with minimal infrastructure investment and volume-based operating costs.

## Deliver virtual Care@Home / “Care Anywhere”

Covid-19 forced the adoption of telehealth at scale. Care@home is the next evolution of virtual care in which the NHS and private healthcare providers offer a wider range of services virtually. Patients have rapidly adapted to using virtual consults and practicing in-home care – and there is room for still greater adoption. Many chronic conditions can be monitored in remote care settings, and some outpatient procedures and follow ups can be effectively virtualised. McKinsey estimates that approximately 20 per cent of walk-in care could be virtually

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delivered, creating a substantial value pool in 2020 and beyond.

Telehealth enables health systems to decouple care delivery from the constraints of their physical infrastructure. We recommend:

- Evaluate existing telehealth capabilities and performance; determine what additional services could be delivered remotely via virtual channels.
- Ensure telehealth workflow is integrated into clinical workflows and electronic health record (EHR) systems to capture documentation for reimbursement and care management.
- Extend virtual care beyond primary care, including chronic conditions such as congestive heart failure, COPD, diabetes and behavioural health
- Streamline referral and prior-authorization processes to make access to in-home care smoother.

### **Implement low-touch healthcare**

The Covid-19 pandemic is forcing healthcare entities to reduce physical contact during care delivery and related administrative processes. A critical challenge here is delivering a personalised, human experience while still practicing social distancing and

contactless processes.

Patients must be confident that medical offices, clinics and surgery centres are safe to visit. Similarly, payers must ensure that members have access to care, especially those managing chronic diseases or cancer. The pandemic presents a new opportunity for the industry to achieve its longtime goal of paperless physician practices by redesigning office processes to digitally enable:

- Scheduling, pre-screening and check in. Enable patients to schedule appointments and check in via mobile devices.
- Check out. Enable digital delivery of visit summaries and orders and digital scheduling of follow-up appointments.
- Payments. Enable touchless payments, including Apple Pay, Google Pay, and others, before or after the visit to avoid physical handling of paper and surfaces.

### **Accelerate digital transformation**

Shifts in consumer behaviour, combined with regulatory easing and powerful new technologies, create a perfect environment for change. Covid-19 has forced most businesses to adopt at least some virtualisation. As a result, technologies and behaviours that were slow to catch on previously appear poised to become mainstays post-pandemic. Forrester Research estimates that worldwide video visit volume will reach a billion transactions in 2020, up from a projected 38 million transactions before the pandemic. To capitalise on this trend it will be critical to:

- Create a digital care ecosystem around existing Electronic Health Records (EHRs) that will enable care anytime, anywhere. This requires creating a scalable and agile architecture and ensuring that EHR vendors can support the same.
- Implement a “digital front-door to care” strategy that delivers a consistent set of experiences for patients regardless of their entry point into the healthcare continuum.
- Modernise data infrastructure to

leverage automation and machine learning to drive better clinical and operational outcomes.

- Transform the IT operating model and move to a product-oriented consumer-focused mindset.
- Build new strategies around increased and improved data flows, including greater use of longitudinal data, AI and analytics.

### **Improve collaboration**

Healthcare stakeholders have an opportunity to work together to engage members and patients to control costs. They can create a model of joint operations to maximise operating efficiency, reduce waste and duplicated effort, maximise information delivery speed and improve stakeholders care. Health organisations may need to revisit assumptions about the size and needs of populations that they serve. Incentives must be aligned across the ecosystem to support new care-delivery models, including services delivered virtually or via care@home. This will require stakeholders to:

- Create a post-pandemic financial recovery roadmap to sustain operations for the new normal.
- Embrace digital transformation and build evidence to validate that virtual models of care will reduce total medical costs and improve outcomes.
- Show leadership in discussing broad technology adoption. Many are hesitant to implement new technologies because they are concerned about adoption. Many of these new technologies have tremendous promise to streamline operations, making this an appropriate time to launch these initiatives.
- Leverage interoperability to create true clinical-data-sharing agreements for clinical insights and decision-making.
- Create mechanisms to create value-based programs leveraging new care-delivery models that incentivise the provider community to invest in digital engagement with patients. ●

**For more information, please visit:**  
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The NHS's sister service needs to be treated as such, says **Munira Wilson**, Liberal Democrat spokesperson for health, well-being and social care

# Don't waste the chance to fix a broken system



**H**istory will judge us by how we treat the most vulnerable and poorest in our society during this pandemic. The situation in social care has undoubtedly been one of the greatest failures and tragedies of our country's response, with too many in the care system overlooked and let down.

We are talking about individuals of all ages who may be frail, and have complex conditions and significant needs. We are also talking about the staff who are often forced to work on the national minimum wage with zero-hours contracts and only statutory sick pay. The unpaid carers of those who have been unable to get the care they need have also struggled during this crisis as a knock-on effect of the care system being left behind.

Yet, despite social care's importance to both the people it serves and to the sustainability of the NHS, it is often described as the "Cinderella service".

When people say this, they do not mean the story where she gets to wear the glass slipper and live happily ever after. They mean the bit of the story where Cinderella is neglected and forgotten. For decades, the system has consistently been overlooked, underfunded and misunderstood. During the pandemic, these issues have only got worse.

At the start of the pandemic, care homes were effectively forgotten by the government. Despite warnings from countries such as Spain of the serious situation that would face care homes, they received inadequate advice and resources. Care homes faced delay after delay in the government's roll-out of a system to provide PPE, while patients were discharged into homes without coronavirus tests.

We know that since the start of the pandemic, close to 20,000 people have died in care homes in England from

Covid-related causes, yet it took until 6 June for the government to offer tests to care home staff and residents (and even this did not include learning disability care homes). Even now, there are yet more delays to the government's regular programme of testing in care homes, which does not bode well as we approach a potential second wave. The case for a full independent public inquiry to learn lessons is unquestionable.

Despite their immense sacrifice and service to this country in caring for the vulnerable, care staff have also been overlooked. People in care jobs are largely on minimum wage and half of them are on zero-hours contracts. Yet they are undertaking highly skilled work, looking after the most vulnerable and providing intimate care.

There are very few career prospects and little training. The pay differential between care workers with less than



## Care staff have been overlooked

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a year of experience and those with more than 20 years' experience has now reduced to just 15p an hour. The case for ensuring that our care workers are at the very least paid the real living wage is overwhelming and a moral imperative.

On becoming Prime Minister, Boris Johnson announced on the steps of Downing Street that he would “fix the crisis in social care once and for all with a clear plan we have prepared”. Yet so far, the only thing he has set out to do differently is change the UK's immigration system in a way that actively harms the already overstretched care system.

A quarter of a million of our 1.5 million care workers – workers we clapped throughout the crisis and who put their lives on the line – are not British and have come here to take care of our loved ones. Under the government's new system, these care workers would not

qualify to move here. When we have more than 100,000 vacancies in the workforce, meaning care needs for many are not being met, this regressive action risks plunging the sector into further crisis.

The first step to doing this is to stop social care being ignored. The Chancellor said he would give the NHS “whatever it needs” to cope with coronavirus, yet no such lofty promises have been made for social care. It is high time that it was recognised as the NHS's sister service rather than a poor relation.

In the longer term, we can also do this by respecting our care workers and funding social care properly. A professional body for care workers should be created where clear career pathways can be delivered, along with training and development opportunities and improved pay structures. Social care funding needs to be more sustainable – the sticking plasters we have seen during the pandemic just will not do.

Care workers have been sharing with me their concerns regarding the long-term impact the pandemic will have on their mental health. Many are feeling exhausted and traumatised by what they have experienced, for which they have had little training. That is why the Liberal Democrats have campaigned for a 24/7 hotline for mental health support for care workers, to ensure they have help when they need it.

Simultaneously, work must begin now to develop a cross-party health and social care agreement. Only a system with broad agreement will survive successive governments run by different parties.

And the time is right to do this. Although the pandemic has been incredibly challenging, it has also brought impetus for real change. The government must use this time now to learn lessons on how we can tackle the issues facing social care. Grave challenges are ahead, particularly with the possibility of a second wave, but there are also opportunities, and one of these is fixing social care. The government must not waste it. ●

# Kick-starting a remote revolution

For many of the challenges escalated by Covid-19, technology could offer the solutions, says **Gavin Bashar**, managing director UK and Ireland at Tunstall Healthcare

**T**he coronavirus crisis has highlighted many aspects of our society that were not previously high in the public's consciousness, increasing the focus on the amazing work of the NHS, and recognising the value of social care. We have also seen how quickly we are able to adopt new working practices if it becomes imperative to do so; initiatives such as remote health monitoring that would previously have taken months to put in place have been operational within two to three weeks.

As a long-established provider of healthcare technology to help people remain independent and access help in an emergency, we at Tunstall have been working with local authorities and the NHS during the crisis to help them support people at home and in care homes.

Community alarm technology, or telecare as it is also known, provides people with the means to easily connect to a specialist monitoring centre at the touch of a button in the event of an issue such as a fall in the home. A discreet worn device can be pressed which will activate a central hub in the home, enabling two-way speech to the operator, who can then despatch help such as a trained responder, family member or the emergency services. In addition, devices such as smoke, gas, flood and fall detectors can automatically raise the alarm to ensure a response if the individual is

unable or unwilling to communicate this themselves.

A rapid response to such events can mitigate their effects; for example, the fire service attending sooner than may otherwise be the case, or avoiding a "long lie" after a fall. As technology advances, we have the capability to not just react to events, but to predict and even prevent them. For example, sensors in the home can detect usage of the bathroom or kitchen appliances. This in turn can indicate a possible deterioration in self-care, nutrition or health.

Tunstall's next generation of technology makes care more personalised and proactive, enabling the right level of care to be delivered at the right time. By integrating different health and care systems through technology, we can move to a more predictive model based on data-driven insights. This Cognitive Care approach



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**Tunstall**



provides an intelligent solution which connects services, helping to transform the way health and social care is delivered.

As much as the pandemic has brought immense pressure to bear on our healthcare system, it has also resulted in unprecedented acceleration in the adoption of technology, and, just as importantly, the new models of care delivery that make the tech a success. After years, if not decades, of

## The pandemic has catalysed the use of technology

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debating the ways we can make our health and care systems more agile and sustainable, it is vital that we don't lose the gains we have made as a result of the crisis. If we can harness the current spirit of collaboration and innovation, the pandemic may yet prove to be the turning point in the UK's health and care systems.

### Case study

Sadly, residents in care homes have been the hardest hit by the outbreak of Covid-19, and as lockdown eases and winter approaches it is vital that we learn lessons from the start of the pandemic and put systems in place to protect some of the most vulnerable members of our society. Bolton NHS Foundation Trust and Bolton Clinical Commissioning Group has deployed Tunstall technology in 34 care homes. Paul Beech, Head of Strategic Commissioning, Bolton

Clinical Commissioning Group, said: "We've introduced various initiatives to proactively support the health and well-being of care home residents, but the crisis meant it became critical to look at ways we could use technology to deliver more care without face to face contact."

Tunstall's ICP triagemanager® and myKiosk™ systems were deployed to enable closer monitoring of the health of vulnerable residents, whilst reducing the need for clinical staff attendance thus lowering the risk of cross infection. Alerting clinicians to symptoms such as rising temperature at an early stage enables faster interventions, avoiding the need for more complex care, improving outcomes and for Covid-19 patients, enabling them to be isolated and treated as soon as possible.

Where care staff have concerns about the health of a resident, they can use the system to record their vital signs and help residents to answer questions about their health. This is then securely transmitted to the patient management software at the Community Services Hub. Results which breach the parameters set for that patient will raise an alert on the system, prioritising them on the triage screen using colour coding. Advanced Nurse Practitioners can review the data enabling them to make an informed decision regarding next steps in the patient's care.

Joanne Dorsman, of Bolton NHS Foundation Trust, said: "The systems give us objective information to support effective clinical decision making. This remote monitoring approach is helping us during the pandemic, but will also enable us to provide more proactive care over the longer term, improving the well-being of residents and helping to reduce the pressure on primary and secondary care." She added: "The success of the programme will be measured over time, with metrics such as reduced ambulance call outs being assessed, as well as resident outcomes and the impact on caseload management." ●

# Burning out during a pandemic



**How Covid-19 exacerbated long-standing problems for NHS staff. By Rohan Banerjee**

**T**he National Health Service is a rare point of consensus in British public discourse. That it is free at the point of need and delivery is held up as evidence of the UK's fair and modern society. Doctors, nurses and support staff are lauded as heroes. So why are so many choosing to leave?

In 2019, research by the Health Foundation think tank found that the rate of personnel leaving the NHS due to excessive stress had nearly trebled over the course of seven years. Between June 2010 and June 2011, 3,689 members of staff, the majority of whom were nurses, cited burnout and a poor work-life balance as key reasons for leaving the NHS in England. That figure was

## A third of staff sick leave is due to stress

10,257 for the 12 months to June 2018. According to the most recent NHS Employers report, stress accounts for a third of all sickness absences among staff, costing the service between £300m and £400m per year.

And that was before the pandemic. Covid-19 has been something of a call to arms for the NHS. Staff have acquitted themselves in managing the crisis, working substantial overtime. But with a second wave looming, a perfect storm of exhaustion and disillusionment is brewing across the healthcare sector.

In August, Dr Chaand Nagpaul, chair of the British Medical Association, told the *Independent* that a second wave of Covid-19 could be accompanied by the “double whammy” of staff shortages and a backlog of postponed operations and treatments from the first wave. Nagpaul said the pandemic had led thousands of staff to consider quitting or retiring early. He added that coronavirus restrictions on foreign travel, which would be further complicated by Brexit, will make it even harder to replace those who do leave.

A junior doctor based in Brighton,



Nurses stage a protest after being left out of a public sector pay rise

who prefers not to be named, tells *Spotlight* that the NHS has become a “far less attractive employer than it was a generation ago”.

“I still love what I do,” he says. “I’m a doctor because I want to help people. But the NHS is only as strong as its staff. And if members of staff are unhappy, overworked or stressed, then that will have a direct effect on the quality of care that the NHS is able to give.”

Though nobody in the medical profession “expects to always clock off at 5pm on the dot”, he adds, this crisis has taken overtime to new levels. But he confirms that staff shortages were a problem even before coronavirus. “It has become almost accepted that every hospital rota is short of doctors. And as those shortages continue, all these targets about patient waiting times and so on are unlikely to be met.”

A nurse practitioner based in Leeds, who also chooses to remain anonymous, says that working during the pandemic has, at times, felt “thankless”.

“The Thursday night applause [when the public was encouraged by the

government to clap on doorsteps once a week in recognition of NHS staff] felt hollow to be honest,” she says, noting that platitudes were not matched by policy. “The failure on PPE [personal protective equipment] meant that you had nurses going into work, putting themselves at risk, every day. It made me feel so anxious.”

In July, Chancellor Rishi Sunak announced an above-inflation (between 2.8 and 3.1 per cent) pay rise for nearly 900,000 public sector workers including doctors, teachers and police officers. But the scheme does not extend to nurses, paramedics, social care workers and other NHS support staff, who are tied to a three-year pay deal that does not end until April 2021. Their salaries will not even be eligible for review until next year. This “feels like a kick in the teeth”, says the Leeds-based nurse.

The pay rise also excludes junior doctors, who make up almost half of the total doctor workforce. They are due a 2 per cent pay rise each year of a four-year deal that began in 2019. “It [the public sector pay rise] is just a headline unfortunately,” the junior doctor from Brighton says, “just smoke and mirrors.”

Suzie Bailey, director of leadership and organisation development at The King’s Fund think tank, and a former NHS general manager, says that while pay is undoubtedly a factor, it is not the only issue. “Of course, people need to be properly compensated for the risks they are taking to keep other people safe”, she says. “But we need to look at how work is structured. There is a debate to be had about 12-hour shifts. A lot of staff can see benefits in working three 12-hour shifts in a row to get more time off during the week, but actually, there is evidence

## “The applause felt hollow to be honest”

to suggest that those longer hours are making burnout more likely.”

Bailey says there are many “cultural” factors contributing to NHS burnout, including how employees are treated by senior staff. “Better management practices are key,” she says. “Staff should feel like they are part of a team, and not hassled constantly to work to certain targets.”

The NHS hero tag is “a bit of a double-edged sword” too. “In painting NHS staff as super-human, you belie the fact that they are, in fact, human.” Bailey points out that the unique pressures of healthcare, namely dealing with potentially traumatic issues, such as patients dying, on a daily basis, can have a profound impact on staff. “And yet there is an expectation that they should become immune to it and just carry on.”

Schwartz Rounds – conversational forums where clinical and non-clinical staff discuss the social and emotional aspects of their work – are one way in which NHS Trusts support employees. Julian Groves, head of staff experience programmes at the Point of Care Foundation, a charity which helps implement these forums, says that the NHS and, indeed, the government have a “moral responsibility” to look after staff.

Groves feels many staff stop working for the NHS because many aspects of the system “do not feel ‘human’ at scale, structure or culture”.

Around 1.3 million people work for the NHS. In 2019, the NHS Staff Survey found that 51 per cent of staff were thinking about leaving their current job, while 21 per cent wanted to quit the service altogether. More than three-quarters of respondents felt they were placed under unrealistic time pressures some or all of the time, and nearly six in ten claimed to have done unpaid overtime every week.

“It’s not enough,” the junior doctor says, “to simply rely on the goodwill of doctors and nurses to keep them in a job. As with any employer, you need to think about how you would attract someone to apply, and how you would convince them to stay.” ●

# Levelling up our digital health strategy

Widening access to the internet will be key to addressing healthcare inequality, says **Sheena Asthana**, professor of health policy and director of the Plymouth Institute of Health and Care Research at the University of Plymouth

**T**he Covid-19 pandemic has accelerated the launch of technologies that support the vision of a digital-first NHS. From the rolling out of Microsoft Teams for healthcare workers, the release of an app that allows patients to access their health information, book and manage appointments and order repeat prescriptions to the offer of free video conferencing services to GPs, the pandemic has seen an unprecedented uptake of technology in healthcare.

The problem with a digital-first NHS is that it only works if everyone is online. However, while virtually all adults (99 per cent) aged 16-44 in the UK were recent internet users in 2019, that figure drops to 47 per cent among adults aged 75 and over.

There is, moreover, a close correlation between digital exclusion and social disadvantage. According to the 2019 Oxford Internet Survey, 95 per cent of those with higher education reported being online, compared to only 36 per cent of those with no educational qualifications. Household income is also a good predictor of internet use; almost all of those earning more than £30,000 a year being online, compared to 60 per cent of those with incomes of less than £12,500.

Unfortunately, older age and social deprivation are key risk factors for diseases such as chronic obstructive pulmonary disease, diabetes and

specific cancers that increase risk of severe illness from Covid-19. For such groups, health inequalities may well be exacerbated by increased social isolation and decreased access to health services due to the need to shield. In some cases, innovative solutions have been found, such as offering access to tablet computers as part of a social prescription. In others, limited progress has been made – for example, not all care homes or shelters provide WiFi for their residents.

Better integration across health and social care is also important in enabling better case decision and improved patient experiences. General practice in England is now virtually digitised (though practices use several, nationally available electronic record systems, which are not always linked to other systems). In contrast, many community and social care providers are still operating with paper records. Even within hospitals, digitalisation and interoperability remain key problems.

A study published last year by Imperial College London found that, of 152 acute trusts, 23 per cent were still using paper records. Of those using electronic records, 79 per cent employed one of 21 different commercially available systems and 10 per cent were using multiple different systems within the same hospital.

Joined up care requires joined up IT systems. Yet, a national decision to invest in areas that were already digitally advanced, has exacerbated the digital divide between geographical areas. Areas such as Greater Manchester and London are now galloping ahead with respect to their digital health ecosystems. In contrast, rural and peripheral coastal areas, that have older populations who are more likely to be digitally excluded would appear to be losing out in a digital strategy that is geographically concentrating rather than trickling down.

To use a current policy phrase, some levelling up is required. ●

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# National health policy must leave no one behind

Northern expertise and resources must not be neglected, says **Dr Séamus O'Neill**, chief executive at the Northern Health Science Alliance

**T**he coronavirus pandemic continues to amplify the devastating effect of health and economic inequity in the UK, revealing a startling truth. Historic under-investment by government in regions with huge unrealised potential, yet with greatest health and economic inequity, can no longer be ignored. Our analysis with the Applied Research Collaborations (ARCs) in the North East and North Cumbria and Greater Manchester, showed that Covid-19 has a greater effect in areas of poverty and, as a result, the impact on the North has been disproportionate, both in terms of death rates and unemployment.

In the North of England, we see the effects of the pandemic amplifying other factors, such as the existing inequalities in health and disproportionately low public sector investment. When the full, but as-yet unknowable, impact of Brexit is added in, we could face a perfect storm. The government seems serious about its pledge to level up the North, and now more than ever, we need action, we need it quickly and we need it at a real scale. By harnessing the expertise and assets within the North's research-intensive universities, major NHS Trusts and four Academic Health

Science Networks, the Northern Health Science Alliance is working to play our part to drive both health improvement and economic growth by brokering research collaborations, attracting investment, and providing a unified voice for the region's health research system.

For too long, opportunities in the North have been overlooked when it comes to investment by government in research and development (R&D). A recent report highlighted the regional imbalances in R&D spending across England which result in the North missing out on an estimated £1.6bn every year. At the NHSA, we understand that part of the ambition in the Comprehensive Spending Review later this year will do something to address this inequity. With the right level of investment, we can build on the collective assets of the North of England life sciences cluster. The region has huge capabilities in health research and innovation with particular strengths across diagnostics, advanced therapies, mental health, and health data. We are offering an opportunity for government to invest in areas of excellence in the North that are crucial to the health of the UK and wider life sciences sector.

We will continue to champion the role of our sector to the assets in the North and we will also work with our member organisations, industry and others who are striving for similar. However, this is a complex issue and the underlying economic and health inequality will not be solved overnight. Reversing the decades of underinvestment and deep-rooted inequalities that are faced by the North, must start with acknowledging the need for change and understanding the societal risks of doing nothing. There is a clear need for action and for sustained investment. We should make an immediate start to build the necessary foundations that will lead to a healthier, more prosperous future for the people and the economy of the North. ●

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