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Academy of Medical Royal Colleges

Multi-professional team-working

The experience and lessons from COVID-19

Contents

Foreword

The COVID-19 pandemic has powerfully illustrated the importance of effective multi-professional team-working in healthcare. Clinical and non-clinical staff have come together in a range of ways, working tirelessly in response to the urgency of the virus as well as helping patients not affected by COVID-19 access other forms of care and treatment. Collaboration across professional groups and across different healthcare settings — long recognised as important drivers to improving patient experiences and outcomes — became crucial factors in withstanding the pressures of the pandemic.

Last year we produced a report on Developing identity in multi-professional teams, which explored professional identities in a changing healthcare landscape. With care increasingly being delivered by those working in new and/or advanced roles, such as Medical Associate Professionals and Advanced Clinical Practitioners, it was timely to consider the impact upon more 'traditional' groups, such as doctors and nurses. Our aim was to encourage the growth of more flexible and collaborative individual and team identities, and to guard against protectionism and silo-working.

When our report was published, the pandemic had just begun to unfold, and few could fully anticipate the effect COVID-19 would have on the health and social care system, and the public consciousness. Many of the recommendations we set out — from teams developing 'shared goals and objectives' to individuals understanding their 'unique skills, attributes and expertise' — have been tested and, in many instances, realised. The pandemic has provided the impetus for important transformations in healthcare but has also stymied other opportunities for change, such as the potential for embedding patient and community engagement in service design and delivery. It has also had a gruelling impact on many parts of the health and care workforce. We are thankful for staff across the system who have come together against the backdrop of such extraordinary personal and professional circumstances to deliver high-quality and compassionate care to patients.

How we 'reset' health and care post-COVID-19 has become a keynote of conversations across health and social care throughout the four nations. While the pressures of the pandemic are likely to reverberate in the months and years ahead, it is vital that we take stock of the experiences from this crisis and the lessons learned for the system, organisations, teams and individuals. In this report, we reflect on what COVID-19 has taught us about the opportunities for and barriers to multi-professional team-working, to help us understand how we can realise the vision for collaborative working across traditional boundaries and hierarchies to ensure the best possible care for our patients.

Professor Helen Stokes-Lampard
Chair, Academy of Medical Royal Colleges

Executive summary

The last year and a half has marked a tumultuous period for health and care systems globally, as they responded to the challenges posed by the COVID-19 pandemic. In the UK, primary, secondary and community care rapidly altered their ways of working both to support patients with the virus and those with a range of other physical and mental health conditions. In this report, we focus on the role of multi-professional teams, considering how the members of different occupational groups came together to deliver care differently during the pandemic.

The report focuses on what lessons we have learned about the enablers for and barriers to effective multi-professional team-working. Drawing on interviews with workers across different specialties, healthcare settings and regions, it explores five key themes that have shaped experiences of multi-professional team-working during the pandemic. These areas should form the backbone of future work to 'reset' team-working after the pandemic, since they offer opportunities to improve and embed collaboration and integration across occupational groups. If the system can address these issues, we can fully realise the benefits of a multi-professional workforce for patient care.

Bringing together individual case studies, broader lessons learned, ten key principles for improving multi-professional team-working, and resources and further reading, this report documents some of the changes we have seen and the opportunities and challenges that lie ahead. It seeks to help health and care workers, teams, organisations and systems — as well as patient groups and the wider public — to understand and navigate these changes. As the pressures of the pandemic subside in the coming years, the COVID-19 response will continue to offer a template for how multi-professional teams can, if properly supported, deliver effective patient care in extraordinary circumstances.


Managing the changing team environment
Team morale and wellbeing
Helping multi-professional teams work differently
Skills development
Dissolving inter-specialty silos
Technological advances

Introduction

Effective multi-professional team-working within healthcare is essential for delivering high-quality patient care. Clinical teams are required to adapt to dynamic working environments and meet the changing demands of an ageing population with increasingly complex needs. The importance of taking a more holistic approach to patient care has led to increased scrutiny of the key enablers for and barriers to colleagues working effectively across different occupational groups. In 2020, we published guidance on how to nurture and develop professional identities in order to realise the full potential of multi-professional teams.

The COVID-19 pandemic has marked an unprecedented upheaval in how teams across a range of clinical settings interact with each other and with their patients. Healthcare professionals were thrust into new clinical environments, required to work within novel and often expanded roles, and to quickly incorporate new technologies and pathways into their clinical practice. These professional changes occurred against the backdrop of significant personal and psychological strains created by the global pandemic.

COVID-19 therefore provides a unique lens through which to examine and scrutinise the dynamics of the multi-professional team. In analysing how the pandemic impacted team-working, we seek to build upon our 2020 report by expanding our understanding of how multi-professional teams across a variety of settings can function more effectively both now and in the future. The NHS People Plan for 2020/21 and Health Education England's (HEE) Future Doctor report both look towards transformed, multi-professional teams, while the latter envisages doctors promoting a culture in which every team member is 'acknowledged, respected, valued, and empowered to accept shared responsibility'. These publications set out strategies to make greater use of skills within individuals and teams, and to provide more effective cross-system collaboration which better fits the needs and preferences of teams and patients. If we harness the lessons learned from the pandemic, these aims can be realised more quickly and effectively.

The last year and a half has illustrated that allowing supported and engaged multi-professional teams the freedom and autonomy to improve and transform services enables collaborative identities to flourish. Many teams were able to transform and adapt themselves in order to achieve a common goal. These benefits must of course be balanced against the detrimental impacts including the loss of training opportunities and the risk of burnout and mental ill-health posed by the pandemic. Improved ways of working have also been difficult to sustain amid the continued pressures of COVID-19 and service recovery. By encouraging and supporting this professionalism long-term, however, we

can help highly skilled and motivated staff to plan and deliver the best possible care for patients while deriving fulfilment from their work.

This report draws on a literature review and series of interviews with healthcare professionals and stakeholder organisations from across the UK. By listening to their experiences, we obtained an understanding of the drivers for and challenges to multi-professional team-working through the pandemic. We conducted a thematic analysis of these interviews and identified a range of case studies, which we have included in the report. Our findings are structured around five main themes which came out of this research:

- Managing the changing team environment
- Skills development
- Technological advances
- Dissolving inter-specialty silos
- Team morale and wellbeing

The close of this report proposes ten principles for improving multi-professional team-working in light of the experiences of COVID-19, aimed at individual healthcare workers, teams, organisations and systems. Through sharing lessons learned from COVID-19 for multi-professional team-working, we seek to empower a range of stakeholders to reimagine ways of meeting the healthcare challenges of the twenty-first century beyond the immediate pressures of the pandemic.

What is multi-professional team-working?

- There are multiple definitions of multidisciplinary and/or multi-professional working but all fundamentally describe a group of individuals who belong to separate professional groups, or different disciplines within a professional group, working together.
- Within healthcare settings, the multi-professional team is often best placed to provide a more holistic approach to patient care.
- Research shows that effectively functioning multi-professional teams are important in improving patient outcomes, reducing risk of harm, and enhancing both patient and staff satisfaction.
- The GMC's What it Means to be a Doctor highlights how team-working can be crucial to professional identity and wellbeing.
- Factors that can hinder or support good team-working include leadership recognition, patient acceptance, resourcing, access to technology, and staff time, as suggested by this rapid review of multidisciplinary working in peri-operative care.
- Our previous report on Developing professional identity in multi-professional teams explored definitions and models of team-working in more detail (pp. 10-11).

Managing the changing team environment

The pandemic resulted in rapid and significant changes to the environment within which health and care professionals work. As well as infrastructural changes due to enhanced infection prevention and control measures, there were often dramatic changes in the composition of clinical teams. Individuals were redeployed to wards away from their own specialty, trainees often did not rotate onto their next expected placement, and many staff had to self-isolate or became unwell, with some working remotely for longer periods of time.

Redeployment of staff

Workforce redeployment resulted in an influx of individuals to acute clinical areas with a high proportion of COVID-19 patients, such as general medical wards and Intensive Care Units (ICU). This included healthcare professionals of all grades being relocated to unfamiliar specialties and clinical environments, as explored in Case Study 1. Spurred on by a profound sense of shared purpose and willingness to 'get their hands dirty', multi-professional teams suddenly found themselves bolstered with numbers but not necessarily specialist knowledge or experience. A BMJ Leader study revealed that 76% of redeployed doctors felt they received appropriate support and training but only 59% were satisfied with the information received. This research found that although redeployment was necessary and beneficial in most cases, there was a need for access to relevant information along with a sense of purpose, belonging and feeling like a 'team'.

Some healthcare professionals that we spoke to reported feeling initially overwhelmed by their new clinical environment. Inevitably a large proportion of the redeployed workforce required a period of familiarisation and training in their new role. This meant existing and often senior members of the team taking time out to provide this instruction during a period of extraordinary strain on their service. Some teams that we spoke to resolved these tensions by using staff who were isolating at home to provide virtual training to new team members. Case Study 2 demonstrates how newer members of the multi-professional workforce, such as physician associates, also helped provide continuity within teams experiencing high turnover. Despite conscious efforts to incorporate different staff groups into useful roles within the team, these potential extra resources were not always fully utilised, as we explore in the next section on 'Skills development'.

Case Study 1: General Intensive Care Therapy at University Hospital Southampton Foundation Trust

The physiotherapists in the Intensive Care Therapy team at Southampton Hospital were ordinarily involved in the early rehabilitation of patients. However, the pandemic dramatically changed their way of working. Their 26-bed ITU was expanded so that the team would regularly treat approximately 60 patients, all of whom were suffering from the same condition. Patients tended to be sedated and prone, meaning the standard approach to rehabilitation was not appropriate.

The therapy team was significantly expanded, including colleagues from paediatric therapy, neurotherapy and musculoskeletal outpatients, as well as a series of individuals who had been redeployed to intensive care (increased to 14 in surge 1 and 15 in surge 2) on top of the nine therapists who already worked there. There was also the inclusion of different healthcare professionals such as interventional radiologists within the therapy rehab team plus non-healthcare professionals, including helping hands in the form of firefighters and police officers.

The large numbers of staff presented challenges as individuals required training and some were unaware how to contribute most effectively on the ward. The multi-professional therapy team within the ITU facilitated an online service to ensure training new members did not take time away from those working on the wards. This training was carried out by colleagues who were isolating, who also contributed to data collection and virtual follow-up clinics. Giving those staff a valuable role and keeping them involved in important non-clinical duties boosted morale.

Throughout the pandemic the team experienced a strong sense of camaraderie. On top of those working on the ward, staff would appear on the ITU and volunteer to help, whether through late shifts, weekend shifts or on call. There was a shared purpose and a desire to help which was unique to the pandemic. This became especially important during the second wave. Physiotherapist Megan Lewis noted how morale was particularly low during this phase of the pandemic, as people felt lethargic about the work as well as tired of wearing Personal Protective Equipment (PPE) every day. She noted how vital it was to support one another and have daily debriefs to talk about the importance of the work that they were doing. Reminding each other about positive patient stories and what they had achieved helped boost their morale, taking care of their mental and emotional health.

Source: Megan Lewis, ICU Physiotherapist, University Hospital Southampton Foundation Trust.

Case Study 2: Physician Associates providing professional continuity, Surrey and Sussex Healthcare NHS Trust

Before the pandemic, all of the Physician Associates (PAs) at Surrey and Sussex Healthcare NHS Trust worked in a single specialty. During COVID, the Trust acquired additional funding and was able to appoint 10 PAs on a year-long fixed-term contract. These PAs were different in that they would rotate throughout acute medicine every four months rather than stay in one place. They also worked weekend shifts to support the Registrar on ward cover. This enabled the Registrar to be more efficient with their tasks and ultimately see more sick patients.

The benefits of rotating these new PAs included allowing them to work with different specialties and members of the multi-professional team, from consultants and junior doctors, to occupational therapists and physiotherapists. This enabled PAs to obtain different skills and knowledge across a range of clinical settings, such as the opportunity to perform the initial assessment of new patients being admitted to the hospital.

Given the high turnover of other staff in clinical teams, PAs had a vital role in providing professional continuity across time. PAs were seen by other team members as the 'glue' that helped keep the multi-professional team-working and communicating effectively. When new junior doctors were deployed to work with these teams, the PAs were available to provide assistance around ward protocols and on-the-job guidance to smoothen staff transitions.

Many PAs reported high levels of professional satisfaction at being given this opportunity to expand their generalist skill set and to interact with others across the multi-professional team. Enhanced appreciation for their potential role within the team by other professionals was felt to present an exciting platform for future expansion of PAs' contribution to service delivery.

Source: Daniel Woosey, Lead Physician Associate, Surrey and Sussex Healthcare NHS Trust.

Visibility

The pandemic enhanced the visibility of different team members, helping their role and importance be better understood by their colleagues (from both their own and different specialties). As described in Case Study 3, seeing and working alongside those with previously unfamiliar skill sets was beneficial for understanding the full potential of the team, augmenting trust in the capabilities of others, and improving collaboration. This enhanced visibility seems to have been a key enabler in dissolving silos between different specialties and teams during the pandemic, as this report from NHS Providers suggests. In an increasingly remote and digitalised professional world, in-person multi-professional interactions offer crucial advantages for embedding new roles and/or for appreciating

traditionally undervalued areas of the workforce (such as Specialty and Associate Specialist (SAS) doctors, many of whom continued working on the frontline in the pandemic).

As reported anecdotally, senior healthcare professionals were often more visible on the wards and spent more time interacting directly with their junior colleagues. This was especially seen in specialties where outpatient clinics or elective interventional procedures were stopped. As demonstrated by the Royal College of Physicians' (RCP) modern ward round case studies, greater senior presence on the wards has the potential to improve the quality of patient care, as well as relationships across the medical hierarchy, and leadership role modelling among junior colleagues. As described in this opinion piece, more frequent senior contact across care settings offered an important opportunity for enhancing training and for providing support and supervision for all staff groups.

Service changes

The pandemic not only engendered changes that demanded flexibility from individuals and teams, but also required alternative care pathways to be designed, changing the healthcare landscape for the public too. There was a drive to treat more patients within community and primary care settings to reduce footfall into the hospital. Meanwhile, the COVID-19 vaccination programme required a range of clinical and non-clinical settings (including pop-up clinics in community centres, high streets, churches and mosques) to be utilised to deliver at pace and scale, as described here. The Nightingale hospitals designed to contend with the expected burden of COVID-19 patients also demonstrated how infrastructure and critical care capacity could be rapidly established across the country.

The pandemic's demands for rapid action and the removal of many bureaucratic barriers prompted an entrepreneurial and innovative spirit across the system. At both a national and local level, staff were empowered and inspired to seek creative solutions to the many obstacles the pandemic presented to delivering services. An example of this can be found in Case Study 4 where a temporary early medical abortion clinic was set up in Northern Ireland.

Before any service changes become embedded, it is important to consult with patients and the public, as it was not always possible to involve them fully during the changing landscape of COVID-19. This BMJ editorial powerfully calls for greater collaboration with patients as we move beyond the immediate pressures of the pandemic. In particular, engagement is crucial to understand better public attitudes towards multi-professional teams and skill-mix changes. This will help ensure new ways of working take into account patients' aspirations, expectations, and concerns. Nationally-led campaigns to develop public understanding of the use of new roles across different care settings may help to embed these changes as they unfold.

Case Study 3: Enhanced visibility of podiatrists in Greater Glasgow and Clyde and Lanarkshire Health Boards

During the COVID-19 pandemic, the role of some podiatrists in these health boards changed. Standard clinics were halted, and the intake of patients was restricted to those with infection or of serious concern. The communication and support between hospital-based podiatrists and community practices increased as the community services needed to identify patients at risk who required hospital access. Enhanced inter-professional relations were achieved by meetings among team leaders to improve the trust and transmission of information.

The hospital-based podiatrists also facilitated video consultations as a way of sharing information with community-based colleagues as well as patients. The team is keen to continue and enhance this new way of working following the pandemic. Video consultations meant the number of patients presenting to hospital and appointment times decreased, benefiting both patients and colleagues. The team also started an app where clinical photos could be uploaded onto patient records which further eased communications and the transfer of information.

The reduced clinics and time spent on consultations meant that the podiatrists were freer to take on additional responsibilities on wards. Existing extended skills such as independent and supplementary prescribing and ordering x-rays enabled the podiatrists to reduce the pressures of patients presenting to GP practices and A&E departments, as well as reducing the need for medical and surgical colleagues to be requested to see patients. Newly learned and acquired skills included phlebotomy and MRI request training, which reduced patient contact with other healthcare practitioners or clinics. Through recognition of these advanced skills and taking on these additional roles, podiatrists became more visible, which helped other staff members appreciate their importance; breaking down hierarchical barriers and improving inter-professional working.

Source: Debbie Wilson, Lecturer in Podiatry, Glasgow Caledonian University and NHS Lanarkshire and Sheryl Braidwood, Advanced Podiatrist, NHS Greater Glasgow and Clyde.

Case Study 4:
Providing access to early medical abortions in Northern Ireland

Up until April 2020, there was no abortion provision in Northern Ireland (NI). Since 2017, the Department for Health and Social Care and the British Pregnancy Advisory Service (BPAS) helped women come to the UK to access abortion. When abortion was decriminalised in NI in 2019, legislation paved the way for services to be commissioned.

When the pandemic began, the NI Abortion and Contraception Taskgroup (NIACT) — a multidisciplinary and multi-agency group — worked together to set up a temporary, early medical abortion service to help patients who were unable to travel to access provision, as they might have done before COVID-19.

The service was rapidly set up in line with NICE guidelines, beginning with two Trusts and expanding to five. Informing Choices NI (formerly the Family Planning Association) agreed to provide a Central Access Point facilitating self-referral and offering non-directive counselling. Belfast Health and Social Care (HSC) Trust was the site of the first service and received the highest volume of referrals, and they developed links with other Trusts.

NI legislation allows for nurse-led early medical abortion services, part of a broader move away from doctor-led services. At Belfast HSC Trust there was a clinical nurse lead and the service was developed by Siobhan Kirk, an Associate Specialist in Gynaecology. Not all staff wished to be involved, so establishing the service entailed finding doctors and nurses who wanted to take part.

Siobhan credits supportive working relationships as key to the service's success. She says that 'camaraderie and team-work' sustained them, including in the face of opposition such as protests, which necessitated enhanced security. To share learning and advice, those involved in service provision used a WhatsApp group to discuss clinical scenarios. Siobhan describes how the service brought together family planning and obstetrics and gynaecology, specialties which might otherwise be separate.

The service also received support more broadly, including from senior management within Belfast HSC Trust, and from organisations such as the Royal College of Obstetricians and Gynaecologists, the Faculty of Sexual and Reproductive Healthcare, and the British Society of Abortion Care Providers. Nicola Bailey, a sexual health services nurse manager at Belfast HSC Trust, who was involved in setting up the service, recently won the Royal College of Nursing Nurse of the Year 2021 award.

Siobhan reflects that, given the challenges of setting up the service, it might not have been something she would have become involved with, were it not for the pandemic creating unmet patient need. Reflecting on what she has learned from the successes of the service, she highlights

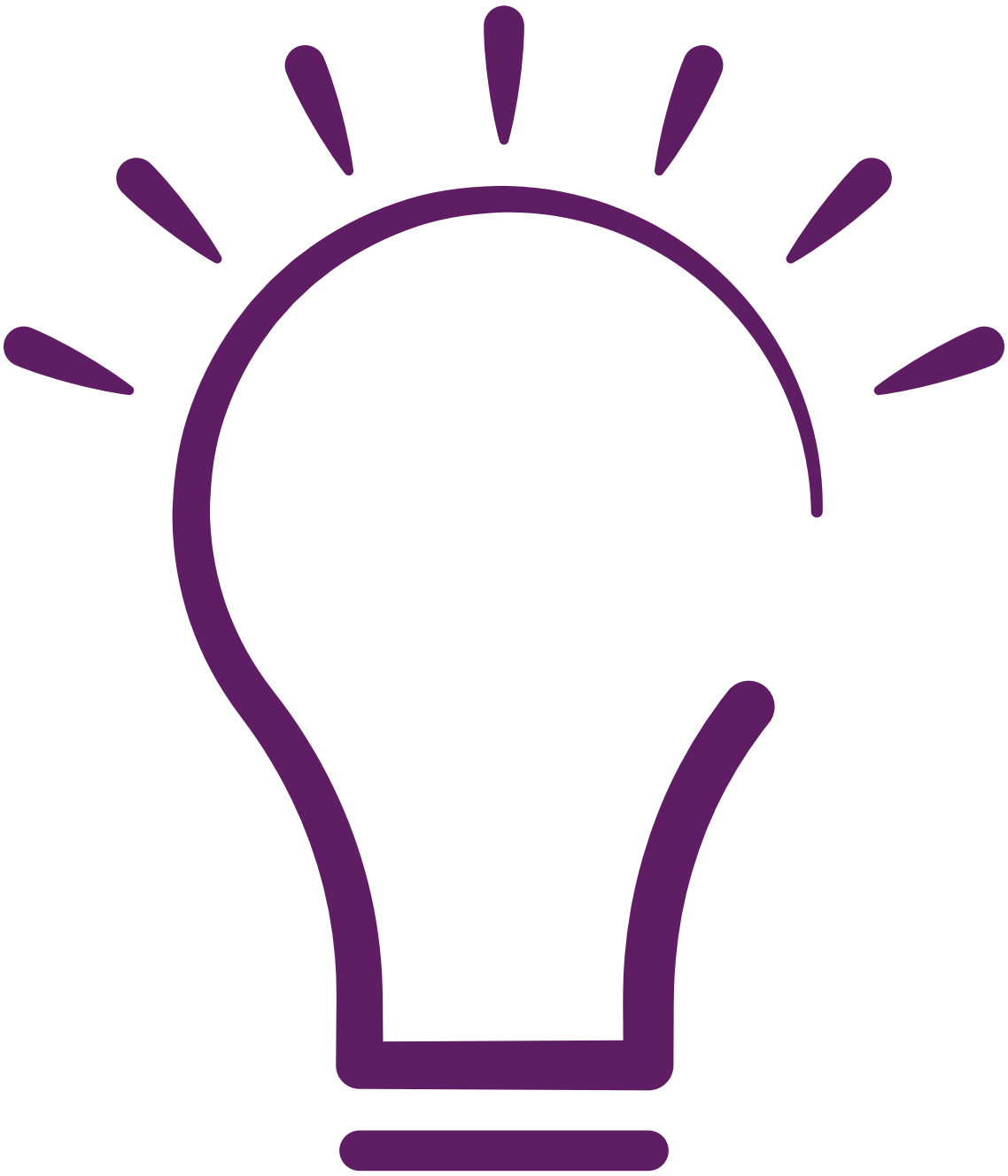
the power of multi-agency and multidisciplinary team-working and collaboration, advising *'don't be scared to pick up the phone and speak to people — communication is more powerful via phone than email'.*

Looking forward, the service is hoping to expand to include treatment over 10 weeks and a surgical option, and is seeking commissioning and funding, working through NIACT. The commissioning board is exploring how the current service is running. The early medical abortion service necessitated by the pandemic has provided a possible blueprint for what a funded service might look like.

Source: Siobhan Kirk, Service Improvement Lead for Sexual & Reproductive Health and Associate Specialist in Gynaecology, Belfast HSC Trust.
Contact: siobhan.kirk@belfasttrust.hscni.net

Further reading:
Kirk S., Morgan L., McDermott S., et al. 'Introduction of the National Health Service early medical abortion service in Northern Ireland – an emergency response to the COVID-19 pandemic'. *BMJ Sexual & Reproductive Health*. Published Online First: 12 January 2021. doi: 10.1136/bmj srh-2020-200920

Skills development



The pandemic placed many staff groups in new and unfamiliar clinical environments. In this context, skills acquisition and enhancement were paramount, as was enabling staff to work to the top of their competence. Healthcare practitioners were expected to adapt to a rapidly changing situation, from incorporating use of PPE to being redeployed to different specialties. As we have identified, staff variously found themselves more visible on the wards or delivering care virtually, perhaps working in different teams or with new colleagues in more restricted settings.

Broadening clinical skill sets

Many practitioners took on new challenges and responsibilities, while increased multi-professional team-working enabled some staff to better appreciate the versatility of their own skills as well as the capabilities of other occupational groups. Flexibility in the scope of staff roles and in deployment was beneficial for 'developing wider skill sets and increasing motivation', as this report from NHS Providers indicates. In a blog post for the Royal College of Anaesthetists, Ellie Crook — a registrar in sexual health and HIV — relates being redeployed to an ICU, emphasising how training opportunities, support from colleagues, and reassurance she would not be expected to work beyond her capabilities enabled her to embrace her new role and appreciate how 'transferable' and 'valuable' her own skills were. Case Study 5 describes how a new eye care service in Greater Manchester entailed optometrists in community settings taking on an expanded role, working with hospital-based ophthalmology colleagues, and Case Study 6 details how advanced clinical practitioners in a primary care setting were given opportunities for upskilling via support across virtual platforms.

Over time, a generalist medical skill set came to be highly valued in the management of patients with COVID-19. Launching its Future Doctor publication, HEE reported that the pandemic highlighted 'how crucial generalist skills are in enabling clinicians to manage complex patients across multiple specialties'. Having competencies in the assessment and management of these patients and the allied services that they may require was essential for a well-functioning multi-professional team.

As we emerge into a future healthcare landscape of significant multi-morbidity and frailty, cultivating improved generalist skills among the workforce is essential for delivering effective care, as this article in the BMJ articulates. Building on the Future Doctor report, HEE is currently developing an Enhancing Generalist Skills Programme for doctors, to embed generalism in medical training. Further, our interviewees also emphasised how the pandemic might act as a platform for promoting the need to maintain these broad skills across the workforce so that staff may be flexibly deployed across care settings during future acute surges in demand.

Expecting flexibility in the workforce risks increasing the pressures upon training time and requires staff willingness to work across a range of care settings. During the pandemic,

senior leaders recognised the unfamiliar environments and additional pressures within which staff were working, as this joint letter to clinicians attests. If staff are to work flexibly in an effective and fulfilling way, then they must not be burdened by a fear of increased risk from working in an unfamiliar environment. Not only must we train and maintain a workforce with more generalist skills, but we must also create an environment that values and empowers this approach to patient care.

Case Study 5: COVID-19 Urgent Eye Service (CUES), Greater Manchester

Working together, the Manchester Royal Eye Hospital (MREH) and a network of optometrists in Manchester and Trafford developed the COVID-19 Urgent Eye Service (CUES), which helps patients access more local urgent eye care. Community-based optometrists assess and treat patients via telephone, virtual and face-to-face appointments, and can seek opinions from or refer patients to the hospital where necessary.

Prior to the pandemic, ophthalmologists at MREH were already considering new pathways and technologies to reduce footfall into the hospital and to make better use of the skills of optometrists. COVID-19 accelerated these efforts, increasing the impetus to treat patients away from the hospital where possible, and the CUES model was recommended nationally in April 2020. In Greater Manchester, pre-existing relationships with commissioners and the local eye health network were crucial to getting the new service off the ground so quickly. Those behind the service credit this pre-existing 'culture of collaboration' as imperative to its success.

A wide range of colleagues across primary and secondary care proved instrumental to setting up the service — from ophthalmologists, optometrists and nursing teams, to staff in administration and IT, who helped deliver the OPERA system which enabled optometrists to send referrals to the hospital.

Further upskilling of the optometry workforce has been a key component of the CUES work. Prior to the pandemic, HEE funded Independent Prescribing (IP) placements at MREH for optometrists. CUES is keen to further develop the IP skills of the optometrists involved, so that they are able to handle a case mix of even greater complexity. This will enable optometrists to work more autonomously and efficiently while ensuring appropriate governance, and will also allow CUES to grow. The MREH team is interested in exploring ongoing training opportunities for primary care partners and seeks to guide them to co-manage patients. At present, optometrists in primary or community care settings tend to develop their skill set through direct patient contact, but there is a risk of silo working, which more opportunities for distance learning can help tackle.

To sustain the ethos of multi-professional collaboration, CUES entails regular meetings between secondary and primary care to resolve any issues and to prevent silos. One initial challenge of working across different care settings was the barriers to accessing data on patients who were

not referred to the hospital. This barrier is being resolved and one initial analysis of non-referred cases to establish the clinical safety of the service has been completed and looks very reassuring.

CUES has received the support of commissioners to continue beyond the pandemic and so these opportunities for upskilling the eye care workforce and for strengthening relationships between professional groups will be explored further.

Source: Bill Newman, Consultant Paediatric Ophthalmologist & Medical Director and Robert Harper, Optometrist Consultant, both Manchester Royal Eye Hospital.
Contact: william.newman2@mft.nhs.uk and robert.harper@mft.nhs.uk

Further reading:
Harper, R.A., Dhawahir-Scala, F., Wilson, H. et al. 'Development and implementation of a Greater Manchester COVID19 Urgent Eyecare Service'. *Eye* 35, 705–708 (2021). doi: 10.1038/s41433-020-1042-6
Kanabar, R., Craven, W., Wilson, H. et al. 'Evaluation of the Manchester COVID-19 Urgent Eyecare Service (CUES)'. *Eye* (2021). doi: 10.1038/s41433-021-01522-0

Case Study 6: Optimising and upskilling the ACP workforce at Haxby Group, North Yorkshire

Haxby Group, which provides GP services in York and Hull and which we profiled in our last report, utilises a wide multi-professional team including a range of advanced clinical practitioners (ACPs), from paramedics to physiotherapists and mental health workers to physician associates.

Mark Coultate — Head of ACP Operations, ACP partner, and a paramedic in his sixth year at Haxby Group — describes how ACPs initially required more supervision when they began working in a primary care setting. At first, they shadowed and offered joint clinics with GPs. Over time, new ACPs began to shadow ACPs instead and there were joint ACP clinics.

Over the last 12 months, the ACP workforce within Haxby Group have developed specialist areas. Physiotherapists run musculo-skeletal clinics, while paramedics cover much of the home visiting, and mental health nurses run mental health clinics. Patients can be booked directly into specialist clinics, freeing up doctors' time for cases where their specific skill set is required. Mark comments that the pandemic has further highlighted the shortage of doctors, emphasising where the ACP workforce can crucially relieve pressures and support patients.

During the pandemic, support and training for the ACP workforce shifted to new virtual formats, reflecting changing ways of working. To support these colleagues in their day-to-day practice, there is a debrief after each morning and afternoon session in which GPs and ACPs meet for half an hour to discuss the caseload. The debriefs typically happened in a group setting, but had to be paused in the pandemic due to social distancing. Now, one GP will typically meet with one ACP, sometimes in the same building or across a virtual platform. Continuing these debriefs despite service pressures is crucial to support patient safety and learning.

Each fortnight Haxby Group has an hour blocked out for a group tutorial, in which a GP guides ACPs through a particular subject. It took a few months to develop a virtual alternative after COVID hit, but the Group has now moved from having separate GP-led tutorials across each of its three sites, to one joint virtual tutorial via Zoom. This new model requires only one GP rather than three, while ensuring inter-professional group learning continues.

Through adapting to new models of working, Haxby Group can continue to upskill its ACP workforce in effective but resource-efficient ways, while the increasingly confident ACPs are empowered to develop specialist services to relieve pressures and meet patient needs.

Source: Mark Coultate, Head of ACP Operations and ACP partner, Haxby Group.
Contact: mark.coultate@nhs.net

Nurturing the team's full potential

Not all practitioners' skills were necessarily harnessed fully during the pandemic. Research commissioned by HEE into use of Advanced Practitioner roles, undertaken in May 2020, found that skills utilisation and optimisation were variable. Positively, over 70% of respondents (from a range of clinical professions) felt that the COVID-19 response had created opportunities for them to develop their skills and knowledge. Almost half felt their advanced skills were being fully used, but this leaves a sizeable cohort whose skills could be utilised more effectively. HEE's report called for colleagues and employers to be better informed and educated about advanced practice roles, to help 'unlock their full potential'.

The focus on skills optimisation and on upskilling across occupational groups should be retained beyond the pandemic, to enable all staff to work at the top of their licence within their scope of practice and competence. The NHS People Plan 2020/21 called for 'a continued focus on upskilling', to develop and expand capabilities, with the aim of creating a more flexible workforce, improving morale and supporting career progression. This must be accompanied by improved recognition and utilisation of the skill mix that already exists within teams. While the pandemic has provided the impetus for different staff groups to have their capabilities better understood and optimised, this momentum must be sustained amid new pressures and current gaps in skills utilisation should be addressed to ensure all staff are able to perform to the best of their ability. Further, statutory education

bodies and managers must consider how to ensure that there are enough appropriately placed educators and supervisors available to train and support staff working in new roles.

In our Developing professional identity in multi-professional teams report, published last year, we highlighted some of the reasons for resistance to new roles, including the possibility that clinicians may be 'reluctant to cede tasks that they feel competent to perform and enjoy undertaking'. Amid the pressures of service recovery and the backlog generated by the pandemic, many clinicians are seeing more complex cases, while more routine tasks may be taken on by other professional groups. While utilising and upskilling advanced practitioners, the case mix and workload of clinicians must be considered, since continually working at a high intensity risks burnout. Optimisation/upskilling should be used to help alleviate pressures, support patient care and help colleagues find satisfaction and fulfilment. But the distribution of work must be managed to ensure that all staff can benefit from new ways of working to deliver effectively for patients.

In the wake of the pandemic, attention should be paid to how different models of training can promote skills enhancement across the multi-professional team. Simulation has typically been used for developing technical skills, but can also be utilised successfully for learning non-technical skills such as communication, decision-making and team behaviours. In this article, Steven Yule (Professor and Chair of Behavioural Sciences, University of Edinburgh and Director of Non-Technical Skills, Royal College of Surgeons of Edinburgh) explores how such skills are important both during a pandemic response and in 'rebuilding capacity' afterwards. In an interview for our report, Yule emphasised the importance of cultivating a 'multidisciplinary culture' from the outset of individuals' healthcare careers. He explained how simulation exposes practitioners to the perspectives of others and helps teams build trust away from the pressures and risks of real-life clinical practice. This can help constructive multi-professional team-working become the norm in both high-stakes and more everyday clinical environments.

Technological advances

When the Long Term Plan set out a vision to 'upgrade technology and digitally enabled care across the NHS', it anticipated this shift would unfold over the following decade. Progress accelerated during the pandemic, however, with a decisive move towards greater remote working. Interactions with patients, colleagues and wider professional networks increasingly moved from face-to-face to virtual formats, bringing benefits of greater accessibility and efficiency, while creating new challenges in terms of developing rapport, addressing some inequalities, and managing work-life balance.

Patient interactions

Across professional groups and clinical settings, interactions with patients were facilitated and in some instances challenged by the shift to remote working. Practitioners we spoke to highlighted that, for many patient groups, consultations became more accessible, with patients able to fit their appointments around other commitments. However, as has been identified elsewhere, the shift to virtual consultations risks excluding some patient groups, particularly those with less access to equipment or confidence using technology. This created barriers for already disadvantaged groups, including older patients and those living in poverty. There are also risks for vulnerable patients who may be living in unsafe home environments, since practitioners are less able to ensure consultations are being conducted privately. NHS Digital have produced guidance for mitigating against the risks of digital exclusion in healthcare.

There is a clinical need for some patients to be assessed face-to-face. This includes where they may require physical examination and/or treatment, whether that be a vaccine being administered or physiotherapy exercises being taught and monitored effectively. This principle is also pertinent to mental and psychiatric healthcare, where remote consultations may be unsuitable for patients with cognitive or perceptual impairments or for high-risk patients presenting with acute illness. [Guidance on managing remote psychiatric assessments is available in this article.]

Case Study 7 illustrates how virtual technologies incorporating visual assessment have been utilised even in challenging settings, such as urgent obstetric care. For other patients, treatment within the home environment may be preferable and even beneficial. One participant indicated that some patients did not wish to revisit the hospital setting, since it had become associated with difficult periods of illness and treatment. Health and care professionals should risk assess which patients are and are not suitable for virtual consultations — with regard to both digital inclusion and clinical necessity — to ensure both patient safety and wellbeing.

The potential loss of the more human side of patient interactions has also been identified as a risk of virtual consultations, which needs to be mitigated. A snap poll by the Royal College of General Practitioners [RCGP], undertaken in September 2020, found that 88% of GP respondents said face-to-face consultations were important for building and

maintaining trusting patient relationships. RCGP further highlighted that many patients and clinicians preferred face-to-face appointments, finding it more satisfying. Our interviews reinforced the findings of the RCGP survey, showing that many practitioners look forward to hybrid ways of reaching patients, bringing together remote and face-to-face delivery, when it is safe and appropriate to do so (see Case Study 8). This combined approach will help to balance some of the advantages and disadvantages identified.

Expansion of remote monitoring programmes such as COVID Oximetry @home holds great potential for being able to virtually monitor the health status of patients while at home. This may allow earlier detection of deterioration in the community and empower patients to better monitor their own acute or chronic health conditions. Technology can also help with assessment, optimisation and monitoring for patients who are undergoing or have undergone surgery. The Centre for Perioperative Care (CPOC) suggests that the best way to reduce surgical waiting lists following the pandemic is to increase the effective use of day surgery, including for emergency patients and those with diabetes — technology can help support this.

Remote monitoring programmes increase the size of the responsible healthcare team, which may sprawl across primary, secondary and community settings. Optimising communication and collaborative working across this novel healthcare delivery platform and reassuring patients about the privacy of their personal health data will be key to its future success as the NHS seeks to expand remote monitoring capacity for a range of conditions, including hypertension.

Professional interactions

The expansion of digitally enabled care and remote working has helped build and extend connections across different specialties and care settings, facilitating multi-professional team-working. It has enabled practitioners to find new ways of networking with others in their specialty, including for the purposes of education, training, research and mentoring (see Case Study 8). However, there is also a risk for some practitioners that working remotely can reinforce silos, leading to a loss of opportunities for roles to become embedded and understood by colleagues.

The NHS Staff Survey 2020 showed that experiences of team-working were actually more positive for those required to work remotely due to the pandemic than those who were not. Staff working remotely/from home were more likely to agree that their team had 'a set of shared objectives' and met regularly to discuss the team's effectiveness. They were also more satisfied with the support they received from managers and colleagues. This may be because the initial shift to home working prompted teams to think more actively or creatively about how to engage and support all members working across different settings. Teams must identify what initiatives have been helpful in maintaining their rapport and performance to ensure that the benefits of flexible working can be sustained in the longer term.

With a greater shift to remote working, the learning requirements and opportunities for all occupational groups have changed. Some interviewees suggested virtual clinics were easier for more experienced colleagues to adapt to, since it takes time to acquire competence and confidence in determining which cases need to be seen face-to-face. The new Foundation Programme curriculum, introduced August 2021, explicitly mentions virtual consulting as part of the quality improvement professional capability. Foundation doctors need to be able to demonstrate they can adapt to new patterns of working, including new technologies, to enhance patient care. Some trainees have voiced concerns that the loss of informal opportunities for exchanges with colleagues has led to an erosion of more serendipitous teaching moments. Those with responsibility for educating their colleagues should ensure that these lost opportunities are minimised and that new ways for the effective delivery of training are instituted. As explored in 'Skills development', remote technologies — such as simulation — may provide creative ways in which to deliver training for multi-professional teams.

Case Study 7: Remote assessment of pregnant patients in emergency care, London Ambulance Service NHS Trust

Prior to the pandemic, the London Ambulance Service NHS Trust already harnessed the skills of a range of clinicians (in addition to paramedics) to deliver patient care. Midwives working in the service provided education and training for ambulance clinicians and enhanced obstetric assessment for advanced paramedic practitioners (APPs) in urgent and critical care pathways.

When COVID-19 presented unprecedented demands, the Trust had to think differently about how best to utilise this model to benefit patients. In the control room, the maternity team worked alongside APPs to provide enhanced triage, enhanced assessment, and (where necessary) onward referral without the need for ambulance conveyance to the emergency department. This trialled a new process for delivering patient care using a complementary multi-professional team. It enabled patients, at a worrying time in their pregnancy, to speak directly to a clinician with enhanced skills and knowledge.

Through the use of a video consultation application, 'GoodSAM', and newly created guidance on assessing bleeding in early pregnancy, the Trust's APP and maternity care team worked together to develop an innovative method for treating patients. One challenge of assessing blood loss in a non-visual environment, such as the control room, is that it relies upon the patient's perception. The use of GoodSAM enabled women to use mobile phone cameras to show their level of blood loss, which was crucial for clinically appropriate assessments.

Reflecting on the advantages that this visual assessment offered to patient care, consultant midwife Amanda Mansfield recalled one case where a woman was observed to be lying on the floor while awaiting an emergency ambulance. Amanda was able to instruct the woman's

husband to clear the hallway of obstructions and to maintain a visual assessment of the patient until the crew arrived.

There were challenges to using video consultations for urgent obstetric care, including helping patients to feel comfortable with live-streaming intimate images. The approach needed to be trusted by service users and meet governance and GDPR requirements. Georgette Eaton, Clinical Practice Development Manager for the APP programme, describes how service design was an 'iterative process', with practitioners learning over time what concerns patients had and how these could be addressed. The need for an acute response initially stymied opportunities for patient and community engagement, but this is becoming more central to the service's development.

The new approach to obstetric cases revealed broader gaps within patient care. It was generally observed that many patients were not registered with a GP and lacked antenatal support, circumstances which sometimes (but not always) overlapped with health inequalities and socio-economic deprivation. Within the Trust, the new ways of working strengthened the relationships between midwives and APPs — whereas previously the relationship had centred around education, it became more practical, with greater integration on an operational level.

The model adopted by the Trust was, to some extent, an acute response and APPs have reverted to their original rotational model, though some remain in the control room. The approach has had a longer-lasting impact, however. Early pregnancy pathways currently exist variably, and this is not usually an area where the ambulance service is traditionally involved. Drawing on lessons learned, the Trust is continuing to use visual assisted guidance for remote consultations and assessment of bleeding in early pregnancy. Pan-London pathways are being developed to help ensure patients are appropriately assessed by a specialist in a timely way.

Source: Georgette Eaton, Clinical Practice Development Manager, Advanced Paramedic Practitioner Programme (Urgent Care) and Amanda Mansfield MBE, Consultant Midwife, London Ambulance Service NHS Trust.

Case Study 8: Remote consultations for highly specialised services, University Hospital Southampton NHS Foundation Trust

The shift to virtual consultations has proven effective for multi-professional services delivering extremely specialist care to patients from a wide catchment area. At University Hospital Southampton NHS Foundation Trust, The Face Place — a facial palsy rehabilitation service within Wessex Neurological Centre — and the paediatric primary ciliary dyskinesia (PCD) service both report largely positive experiences of remote consultations. In both services, virtual consultations

had been used prior to the pandemic, but COVID-19 provided the impetus for these to be rolled-out more rapidly and on a wider scale.

The Face Place focuses on facial palsy rehabilitation, supporting patients who often travel long distances for multiple appointments. The PCD service is one of only four in the UK that diagnoses and manages people with a rare respiratory condition and, as a result, it also covers a wide geographical area. In teams such as these, it is crucial for members to communicate effectively to coordinate complex cases and deliver joined-up care. Both services found virtual working made it easier to bring together the wider multidisciplinary team and to involve colleagues elsewhere in the hospital in patient appointments.

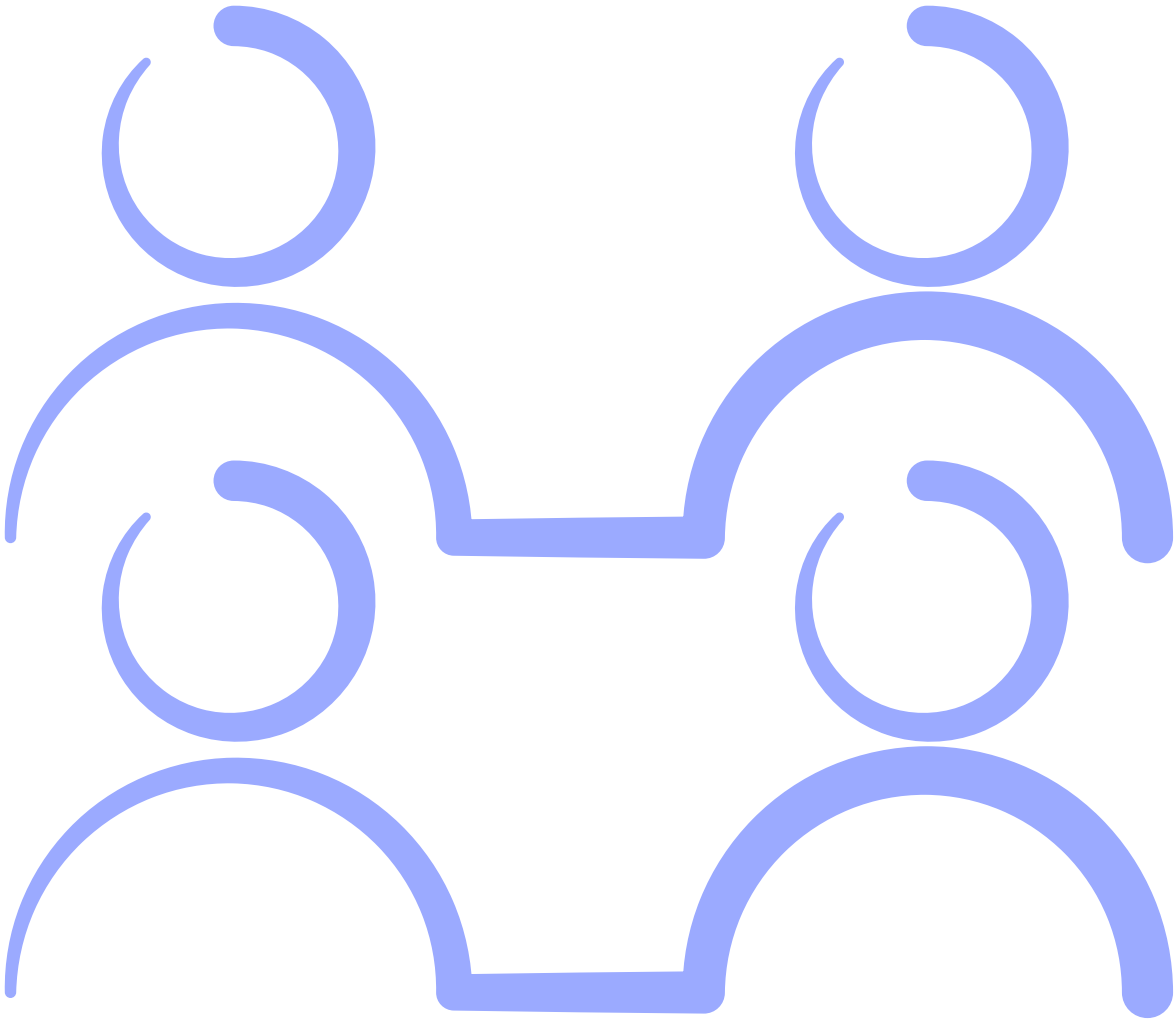
Julie Lovegrove, facial rehabilitation specialist at The Face Place, reports that the virtual platform offered a positive experience for both patients and the multi-professional team, even in a clinic which requires a visual element (e.g. teaching stretches and massage). Since some patients were struggling to access other appointments, the service had to alter its approach to encompass aspects such as eye care and mental health, while making clear they were not specialists in these areas.

The PCD team encompasses colleagues at both the hospital and the University of Southampton and virtual team meetings made it easier to include everyone in discussions, explains paediatric physiotherapist Hannah Wilkins. The service runs along a 'hub and spoke' model, working with patients' local hospitals, and virtual platforms made this easier. Education and training is also a core component of the service's work. During the pandemic, the team was able to offer virtual sessions to local doctors, health visitors, teachers and other caregivers to educate them about the rare condition of PCD.

Both Julie and Hannah reflected on some of the drawbacks of the shift to virtual working. Some patients did not have or were not confident using the equipment, and calls could be affected by poor lighting, slow internet connectivity and the loss of opportunities to read body language. Professionally, pre-existing team cohesion was key as there was less chance for socialising, while protecting work-life balance was also cited as a challenge of working flexibly. In both services, it is likely a hybrid model of virtual and face-to-face appointments will become standard, to retain the benefits of technology while plugging some of the specific gaps identified.

Source: Julie Lovegrove, facial rehabilitation specialist, The Face Place and Hannah Wilkins, paediatric physiotherapist, PCD diagnostic and management service, both University Hospital Southampton NHS Foundation Trust.
Contact: julie.lovegrove@uhs.nhs.uk; hannah.wilkins@uhs.nhs.uk

Dissolving inter-specialty silos



Over the course of a patient's healthcare journey, they will likely interact with a range of distinct medical or surgical specialties. Multi-specialty input on patients is becoming more commonplace, given the population's needs are increasingly complex due to ageing and the prevalence of multi-morbidity.

The majority of healthcare professionals will have some experience of fractured relationships and/or communication between members of different specialties. Dysfunctional inter-specialty relationships and silo-working between different teams pose a material threat to clinical effectiveness, patient safety and experience, as seen in a BMJ article.

From a healthcare leadership perspective, improving inter-specialty relationships is therefore one of the most significant challenges in improving organisational and system output. The pandemic presented an opportunity for a reimagined relationship between certain specialties. With the impetus of the unknown threat of COVID-19, different specialties united around a clear shared goal. This singularity of purpose seemed to focus minds on developing more efficient, compassionate and innovative ways of working. Specialty teams were inspired to display a flexible approach to pathway design and care delivery infrequently encountered under normal circumstances.

Prior to the pandemic, it was common for disputes to arise over which specialty team should have overall responsibility for a patient being admitted to the hospital. A scenario for an elderly, frail patient who falls and suffers a pelvic fracture is represented below. This is one example from a series of clinical scenarios we presented to National Medical Director's Clinical Fellows during focus groups aimed at scrutinising how the pandemic changed inter-specialty relationships. Participants were asked to consider what the key enablers for improving inter-specialty working and collaboration in this case were, and how these improvements might change this patient's journey.

Due to the extraordinary demands upon 'front-door' services such as emergency medicine and the acute medical team during the pandemic, specialty teams tended to be more willing to provide early assessment and acceptance of the type of patient highlighted in the example. In practice, this has streamlined patient journeys that can be prolonged by inter-specialty disputes over ownership. The key enablers identified for this improved flow of patients from the front-door to the wards were two-fold. First, the increased presence of senior decision-makers at the front-door of the hospital meant earlier definitive admission and treatment plans could be taken. Second, the dramatic reduction in non-respiratory illness patient numbers seen across the whole system meant that these specialty teams had the cognitive bandwidth and resources to be able to offer this enhanced assessment service.

Example of challenging inter-specialty working

An 85-year-old woman was admitted to hospital via an ambulance after her neighbour found her on her kitchen floor after experiencing a fall. The woman was lucid but in pain and the impact of the fall resulted in a pelvic fracture not requiring operative intervention.

On admission to hospital, past medical history of the patient revealed that she has known aortic stenosis, hypertension and chronic obstructive pulmonary disorder. Further examinations and assessments determined that the patient was frail. She lives on her own at home, but frequently has neighbours check in on her.

After general assessment, the emergency department experienced difficulties in referring the patient onwards to the most appropriate inpatient specialty team. Although her pelvic fracture may ordinarily be managed by the trauma and orthopaedics (T&O) team, the non-operative nature of her fracture, her frailty and co-morbidities meant that the T&O team were keen for her to be managed by the general medical team. The medical team points out that medical wards have very limited expertise in managing the Pain-Controlled Analgesia (PCA) or specialist regional nerve block this patient may require for pain management.

The benefits of greater clinical collaboration across teams were also seen in the community and in primary care. General Practitioners found that specialty teams were more responsive to requests for specialist support in managing patients with complex needs in the community. This Care Quality Commission (CQC) report highlights examples of improved quality of care due to enhanced collaborative working across different care settings during the pandemic. We also heard of instances where improved communication across care settings empowered GPs with the knowledge and information required to be at the centre of their patient's healthcare journey and coordinate their care more effectively. This more holistic model of care avoids excessively dividing a patient's medical conditions along individual specialty lines and resonates with the Rethinking Medicine agenda. Additionally, a variety of alternative and previously under-explored sources of care came to prominence during the pandemic. For example, a parish nursing care service's contribution to the local community's health is highlighted in Case Study 9.

Redeployment and the migration of specialists towards the front-door of the hospital also offered the opportunity for members of different specialty teams to work in closer physical proximity than ever before. This increased awareness of the day-to-day nature of other's clinical roles. Enhancing empathy for another's stresses and responsibilities is crucial for building a compassionate working culture. This culture can be used as a springboard for improved communication, trust and willingness to help each other. The uncertainty and anxiety surrounding working on the clinical front-line of the pandemic promoted further cohesion but also created tensions, as we explore in the next section.

The understandable concern of our focus groups was that relationships between specialty teams will return to the status quo as we emerge from the pandemic. Indeed, focus group members reported many instances in which this has already occurred. Increased demands upon the workforce during the recovery period and during what will likely be a busy winter will mean that all services are under pressure. Exacerbated by ongoing workforce pressures, there is a danger that specialties will return to a protectionist approach of siloed working. As the threat of COVID-19 begins to reduce, the sense of a shared goal transcending different specialties may also wane.

The Academy recognises that education can reinforce silos. As described in our previous report, transdisciplinary learning and working — with skill-sharing between all team members in pursuit of a common goal — is crucial to breaking down boundaries and fostering a blended team with a sense of common purpose. Strong compassionate leadership is also required across the system in order to encourage ongoing collaboration between teams. Even in a post-COVID-19-pandemic world, a shared goal still exists; namely, acting as a single team to maintain patient and population health. Systems and leaders should help cement this as a guiding principle, role modelling the approach for different occupational groups to follow.

Case Study 9: Parish nursing for vulnerable patients, The Steeple Church, Dundee

Parish nursing at The Steeple Church in Dundee began in 2008, providing a community-based service targeted at inclusion health groups, including people who experience homelessness. The service recognises how these vulnerable individuals can fall through our fragmented health and social care systems to the detriment of their health and safety in the community.

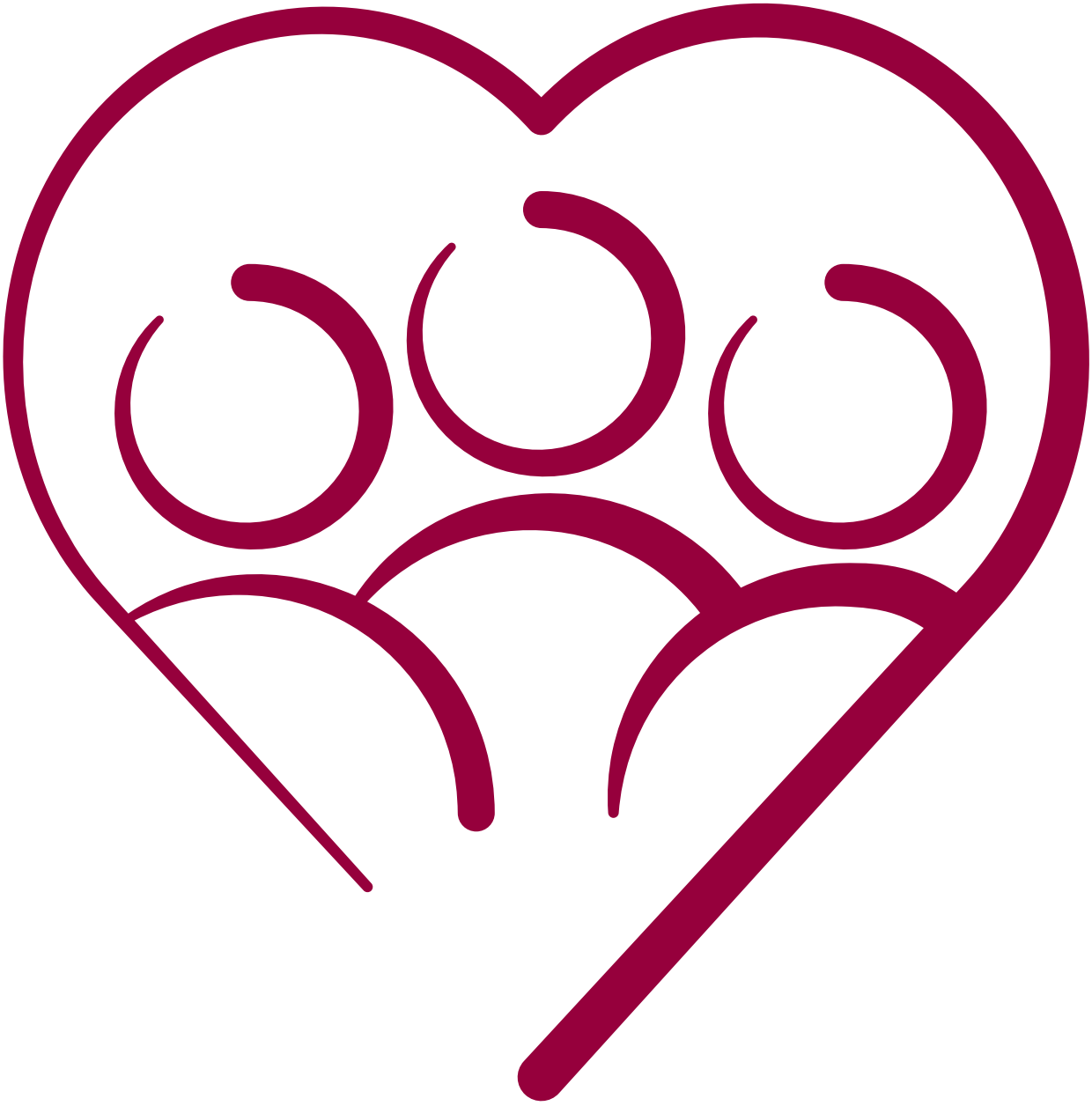
The COVID-19 pandemic enhanced the importance of this parish nursing service within the community. As well as providing food and wider social support to these patients, the service strengthened its connections with primary and secondary care clinical services, and was therefore able to play an enhanced role in the local healthcare system.

During the pandemic, many patients were reluctant to present directly to secondary care due to fears over contracting COVID-19. Exacerbated by longstanding primary care access issues, many of these patients saw The Steeple Church as a highly accessible place to seek healthcare advice and support during the pandemic. The parish nursing team performed duties ranging from wound assessments and medication regime clarification, to mental health support. They provided an informal form of early-triage to establish whether a patient should seek further expert medical input with a GP or in secondary care. Given the increased pressures upon the parish nursing team to perform these duties during the pandemic, strengthening their communication and inter-specialty collaboration with formal care settings was vital for transitions in patient care.

The parish nursing team was able to provide a holistic approach to these vulnerable patients' care needs at a time when other care settings were overwhelmed, or unable to provide face-to-face appointments or support. The familiarity and security provided by The Steeple Church allowed for continued rapport and relationship-building with patients. Provision of food, company and conversation were highly valued by both patients and nurses alike. The Church worked with tenacity to build better working relationships with statutory and voluntary agencies, thereby breaking down traditional silos between these groups. The Church is able to provide a whole-person centred approach to care for patients of all faiths and none, to help prevent loneliness and isolation. The importance of this was particularly clear during the pandemic.

Source: Barbara MacFarlane, Parish Nurse, The Steeple Church, Dundee.

Team morale and wellbeing



Team morale, camaraderie and supportive working relationships have previously been identified as a 'buffer' or protective factor when it comes to practitioners' mental health and wellbeing. These factors were thrown into sharp relief during the pandemic, when colleagues' aims and priorities increasingly coalesced around tackling waves of the virus (as seen in Case Study 1). Some of our participants reported that new ways of working during the pandemic led to a flattening of hierarchies, which meant their roles were better valued and understood, and teams felt more equal. However, there were also clear signs that increased morale was difficult to sustain longer-term across the pandemic, as resources became more stretched and staff more exhausted.

Research by NHS Confederation on the impact of COVID-19 on the female health and care workforce has highlighted that the 'expectation of self-sacrifice' was difficult for staff to maintain. The report identifies 'increased collaboration within teams' and 'compassion from senior staff' as some of the more beneficial aspects, but also shows that, for some colleagues, working relationships were not strengthened but rather fractured and undermined by the pandemic. NHS Confederation heard reports of poor behaviour, including claims of bullying, sexism and racism, which were 'amplified by the pandemic'.

The significant pressures of COVID-19 undoubtedly exacerbated existing burnout among health and social care staff, which has been linked to an excessive workload and workforce shortages. The Health and Social Care Committee's (HSC) inquiry into Workforce burnout and resilience heard about struggles across different occupational groups and in different settings, both before and during the pandemic. In our evidence to the inquiry, the Academy highlighted the importance of evaluating the experiences of multi-professional teams, a recommendation also made by The King's Fund.

A rapid review of the impact of COVID-19 on mental wellbeing found that, while psychological interventions that seek to build resilience in individuals may be beneficial, 'occupational and environmental factors must be addressed' to develop a resilient workforce. (The terminology of 'resilience' has itself been critiqued, as in the Academy Trainee Doctors' Group's evidence to the HSC inquiry.) The review identified some differences in experiences of burnout between occupational groups, but also highlighted the importance of targeted, systemic interventions across the workforce.

In the face of highly pressured and emotionally charged clinical and non-clinical environments, COVID-19 sparked interventions aimed at all occupational groups across the four nations. In England, for instance, 40 mental health support hubs were set up for NHS staff, while in Scotland, an additional £500,000 was made available to health boards to provide dedicated mental health support for health and social care workers. Many of the organisational changes introduced over the last year and a half — from free refreshments and spaces for rest and relaxation to free parking (which should be balanced with the provision of secure cycle storage and shower facilities) — can be beneficial to those from across different staff groups and attention must be paid to how they can be sustained beyond the pandemic.

Individual teams have also implemented initiatives to boost morale and sustain relationships. The shift to remote working, as identified, has presented problems for the loss of interpersonal engagement, and informal opportunities for learning and socialising. Team huddles and debriefs have moved to virtual formats, particularly to support those working from home and/or based across different sites, while there have also been more informal virtual coffees to maintain social contact. Some participants told us that opportunities for building and maintaining supportive networks have been facilitated, rather than hindered, by increased use of technology. At the same time, some staff feel fatigued by virtual interactions, fear the erosion of work-life balance, and would welcome a return to face-to-face contact where safe and possible to do so (see Case Study 10).

Hybrid approaches to team-working, which entail both virtual and face-to-face opportunities for interaction, are likely to become more widespread, but also present logistical challenges that need to be explored. Those participating remotely need to feel as valued as those taking part in person, and the suitability of different platforms must be explored.

In addition to team support, buddying and mentoring can also help deliver more targeted support to practitioners. HEE and the Academy recently developed a new framework for a near-peer support scheme. While this came out of a recommendation in the HEE Foundation Programme Review, and is targeted at doctors in the foundation years in England, the approach could be used with other career grades and occupational groups. More broadly, the Royal College of Physicians and Royal College of Psychiatrists have produced a short guide on the principles and practice of peer support. Organisations such as the Widening Participation Medics Network (see Case Study 11) have been founded during the pandemic, recognising that some members of the workforce may benefit from targeted and bespoke support.

Professional bodies have also played a key role in supporting their members. They have been able to tailor advice to specialty or occupational-specific concerns, though many of the issues raised cut across the workforce and reflect systemic issues. The Royal College of Occupational Therapists, for instance, explained to us how their enquiry line had received an increased number of calls from members about burnout and the expanded scope of practice that impacts on confidence. These fears are pertinent to a range of practitioners working in advanced roles which might not always be well understood by colleagues and employers. Appropriate supervision, training, and support are important buffers against burnout, particularly for those in unfamiliar roles.

During the pandemic, NHS England and NHS Improvement (NHSE/I) brought together organisations representing different occupational groups to discuss health and wellbeing. The Professional Bodies Echo Group enabled members — ranging from the Academy to the College of Paramedics, and the British Dental Association to the Health Estates and Facilities Management Association — to identify common concerns and to share learning from their own initiatives. It also gave professional bodies an opportunity to hear more

about and feed back on the national health and wellbeing offer being developed by NHSE/I and in the devolved nations. Opportunities for collaboration across professional bodies can help strengthen multi-professional approaches to health and wellbeing.

The impact of COVID-19 on the wellbeing of health and care staff has begun to be articulated, and more research is needed to document the long-term effects as the pandemic subsides. The increased attention to addressing mental ill-health and burnout among staff is welcome and more work is needed to determine how best to tailor these efforts to different occupational and demographic groups and to reflect the changing pressures in the health service.

More broadly, it should be acknowledged that while some individuals and teams have had positive experiences of new ways of working in the pandemic — appreciating opportunities to upskill, to work with colleagues more equitably and closely, and to deliver patient care differently — others will have lost training, found it difficult to integrate with colleagues or connect with patients, or have experienced burnout and/or distress. Personal circumstances will also have varied widely, and some colleagues, such as those from minority ethnic backgrounds, have been disproportionately affected by the pandemic. Moving forwards, the health service must maintain a balance between harnessing improved ways of working while directly tackling the challenges and struggles posed by the pandemic.

Case Study 10: Maintaining team morale in a psychiatric setting, Derbyshire Healthcare NHS Trust

The mental health liaison team at Royal Derby Hospital found working relationships with colleagues altered over the course of the pandemic.

As COVID-19 unfolded, ways of working and patient demand changed. The proportion of older adult psychiatric work increased, and a de facto memory clinic for inpatients within the general hospital was established, since patients found it difficult to have remote consultations. This required the multi-professional mental health liaison team to move outside of their 'comfort zone' and flexibly take on additional responsibilities.

Over time, the mental health liaison team found themselves 'more valued and appreciated' in the general hospital setting, explains consultant psychiatrist Simon Thacker. Initially, they tried to shift as much work as possible to virtual formats. However, they realised other colleagues in the hospital expected them to maintain some face-to-face work. Going on the wards and donning PPE helped the team bond with other groups and they learned that giving advice to colleagues in person carried more credibility.

Simon describes how these changes were facilitated by the team's previous experience of 'cohesive multi-professional' working. The transition to virtual meetings meant the tradition of face-to-face huddles was more difficult to sustain, but the provision of large, open-plan offices at the Royal Derby enabled some in-person meetings to continue, with social distancing. Face-to-face meetings also helped the team connect with colleagues in other specialties, including in acute medicine and geriatrics. Meanwhile, Derbyshire Healthcare Trust held regular engagement events online to gauge how new ways of working were impacting staff satisfaction.

Some of the challenges for the team involved sustaining relationships with colleagues in community mental health, which became more fractured in the pandemic, and maintaining training and development to ensure a diverse skill set across the multi-professional team.

Simon credits a number of factors with helping sustain camaraderie and team morale in difficult circumstances, including strong leadership and adequate estate provision, to ensure some face-to-face interaction was possible. 'For teams to thrive, they need decent accommodation', Simon suggests, highlighting the value of balancing virtual models with face-to-face interaction.

Source: Simon Thacker, Consultant Psychiatrist (based at Royal Derby Hospital), Derbyshire Healthcare NHS Trust.
Contact: simon.thacker@nhs.net

Case Study 11: Enhancing the wellbeing of medical students and doctors from underrepresented backgrounds, Widening Participation Medics Network

The Widening Participation Medics Network (WPMN) — a national charitable organisation for aspiring and current medical students and doctors from underrepresented groups — was founded during the pandemic in May 2020. The network's volunteers and members include those who are in higher risk groups for COVID-19, for example students and doctors with disabilities/chronic illness, from ethnic minority groups, from deprived socio-economic groups, and those who care for someone at a higher risk for severe COVID-19.

At the start of their online monthly meetings, the WPMN facilitated debriefings between medical students and doctors across the UK from similar backgrounds. Many concerns were common across different groups of participants, regardless of which specialty they were in or where they were based in the UK. For example, travelling home for Christmas Day may have led to enhanced anxiety for medical students and doctors from underrepresented backgrounds because of the potential increased risk of severe COVID-19 that could be experienced by their families compared

to other colleagues working on the same ward. Several WPMN volunteers had to consider their safety when returning to their job/placement after a period of working from home, e.g. due to a chronic health condition.

The quality of wellbeing support provided by different Trusts to staff has been variable during the pandemic. For instance, while some hospital departments improved their rotas to make them more sustainable for foundation doctors who were nearing burnout, other Trusts did not or were not able to offer such wellbeing support.

The medical students within this network faced many uncertainties, from the timing of when they should receive vaccinations to whether they should be learning on the hospital site at all and which format their examinations would take. Many students will now start F1 having had minimal clinical exposure to several specialties. Providing a support network around these future doctors during these particularly difficult times has been an important function of the WPMN.

Reflecting on these experiences of the pandemic, Jade Scott-Blagrove, the Network's founder, comments that, *'looking forward, we must focus on the type of wellbeing support that doctors and students are asking for — only then will team morale truly substantially improve'*. Jade suggests we should be *'mindful and offer even more support to our incoming F1s because of the impact of the pandemic on their training and mental health'*.

Source: Jade Scott-Blagrove, Founder of Widening Participation Medics Network and ST2 in Radiology at Cambridge University Hospitals NHS Foundation Trust.
Contact: j.scott-blagrove@nhs.net

Further reading: https://www.aomrc.org.uk/blog/jade-scott-blagrove

Conclusion

The COVID-19 pandemic marked a time of unprecedented pressure on the NHS and social care, which accelerated new ways of working at a pace previously unimagined. As the more immediate challenges begin to subside, the recovery of patient care, training pathways and staff wellbeing will be paramount. A return to previous ways of working should not simply become the default, rather there must be proactive engagement to plan for future models of care. Before deciding whether recent changes should be embedded or discarded, it is instrumental that teams, organisations and systems work together to evaluate which changes have proven beneficial and which have been detrimental.

As this report highlights, many of the changes have brought huge benefits to multi-professional working practices and models of care, but also produced challenges and problems which need to be mitigated. The greater flexibility and visibility of different roles, new opportunities for upskilling, expanded use of technology, dissolution of silos across specialties and care settings, and the enhanced sense of common purpose must all be balanced against issues such as digital exclusion, the loss of training opportunities, fractures in some working relationships, and increased anxiety and burnout. Patients and practitioners will have reacted to changes in different ways, and the same change may be positively experienced by some, while negatively experienced by others. Capturing the diverse responses to new ways of working will be challenging, but is crucial to ensure we do not risk further excluding particular patient or staff groups, especially those which have already experienced a disproportionate impact from the pandemic.

Many of our participants identified that the barriers to retaining or expanding new ways of working were due to lack of funding, commissioning, or staffing. While individual staff and team members can evaluate and learn from their experiences during the pandemic, the impetus towards change requires support at organisational and systems level in order to have traction. The COVID-19 pandemic saw a groundswell of support for the NHS and social care from the public and from Governments across the four nations. This must translate into long-term tangible resourcing if the benefits of integrated, upskilled and digitally enabled multi-professional teams are to be realised and retained.

Principles for improving multi-professional team-working in light of the experiences of COVID-19

1. Effective training opportunities for all staff groups must be ensured to support new ways of working. Digitally enabled care requires new skills, previous opportunities for learning should not disappear without adequate substitute, and those who lost training time should be supported to recover. Creative training solutions should be encouraged and tested, such as clinical simulation for non-technical skills.

2. Developing generalist medical skill sets is crucial for potential future acute surges in healthcare demand and to meet changing patient needs. It will allow for a flexible workforce that can be deployed across clinical areas and manage increasingly complex cases including patients with multiple co-morbidities.

3. Continuing to value and nurture upskilling across occupational groups, including new roles, will help empower staff to expand the scope of their practice and will create a more agile and fulfilled workforce.

4. Increasing visibility of all multi-professional team members across healthcare settings will help dissolve professional silos and embed new or unfamiliar roles. Working alongside other occupational groups improves understanding of other's capabilities and potential utilisation in the team, and enhances collaboration.

5. Healthcare professionals and organisations must strive to counter silos between specialties. Strong clinical leadership with effective communication facilitated between both senior and junior members of specialty teams is required to maintain the cooperation seen during the pandemic and create a sense of shared purpose.

6. Maintaining accurate, reliable communication between and within specialty teams across care settings will enhance the quality of patient care. Ease of access to prompt specialty advice and input is crucial for professionals in community, primary, and acute healthcare settings, reducing unnecessary or delayed referrals for further medical care.

7. The use of hybrid models combining virtual and face-to-face options is likely to become standard for patient and colleague interactions. Attention is required to how these models can reduce health inequalities, meet clinical demands, and satisfy both patients and practitioners. There must be rigorous evaluation of new methods and the suitability of different platforms.

8. Hybrid working requires buildings and equipment geared towards both virtual and face-to-face interactions. Physical spaces for rest and relaxation and for teams to come together should be provided, and staff should be furnished with and trained to use equipment for video calls.

9. The pace of change during the pandemic sometimes meant that patients and the public were not involved in service redesign, but their input should be sought as new ways of working and new roles are embedded. Routinely co-producing services with patients can enhance experiences of care and reduce health inequalities.

10. Positive changes during the pandemic typically required supportive working relationships at all levels and across different occupational groups, from managers and commissioners, to collaboration with colleagues in non-clinical roles (e.g. administration, estates, security, and IT). Opportunities for networking and service design across these groups should be enshrined.

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