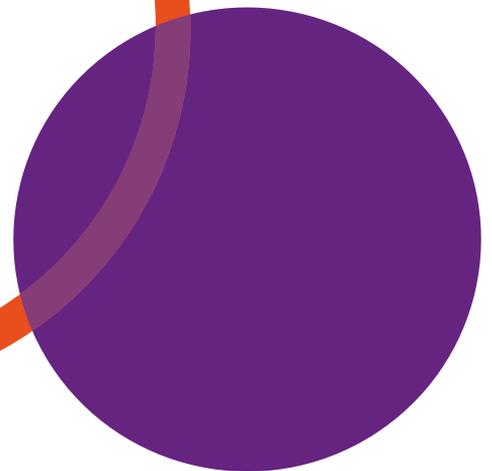
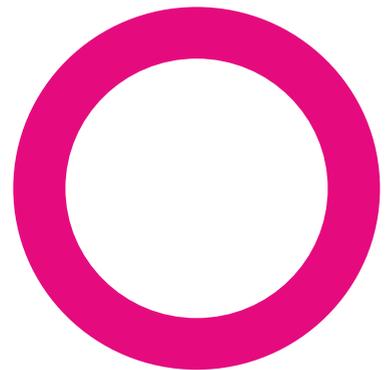
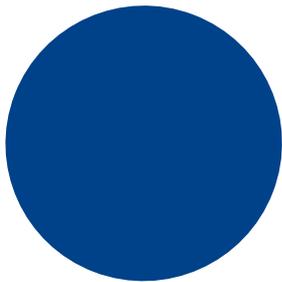


The NHS after COVID-19

The views of provider trust chief executives



Fiona Claridge and Teju Sogbetun

July 2020

About NHS Reset

COVID-19 has changed the NHS and social care, precipitating rapid transformation at a time of immense pressure and personal and professional challenge. One message from leaders and clinicians across the UK has been clear: we must build on the progress made to chart a new course.

NHS Reset is an NHS Confederation campaign to help shape what the health and care system should look like in the aftermath of the pandemic. Recognising the sacrifices and achievements of the COVID-19 period, it brings together NHS Confederation members and partners to look at how we rebuild local systems and reset the way we plan, commission and deliver health and care.

To find out more, please visit www.nhsconfed.org/NHSReset and join the conversation #NHSReset

About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

To find out more, visit www.nhsconfed.org and follow us on Twitter @nhsconfed

Foreword

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Niall Dickson CBE
Chief Executive
NHS Confederation

We are still a long way from understanding the impact of the pandemic on just about every aspect of our lives. But in the NHS, there is widespread determination to use the tragedy and trauma of this terrible virus to change the way our services are provided. Put simply, everyone agrees we will never go back to the way things were and that there is an opportunity to 'reset' the way we deliver care and treatment.

When the virus struck, the NHS in England was emerging from a difficult winter. In spite of extra funding, the service was struggling to meet extra demand, performance and finances were deteriorating, and we were in the early stages of a major transformation programme triggered by the NHS Long Term Plan.

The last four months have turned the service inside out. The extent of changes across the health service has been extraordinary and has been achieved by a Herculean effort from managers, clinicians and support staff. They have also been accompanied by rapid changes in what is done and the way it is done. The oft quoted line from leaders is that what would have taken years has been achieved changes in weeks and sometimes in days.

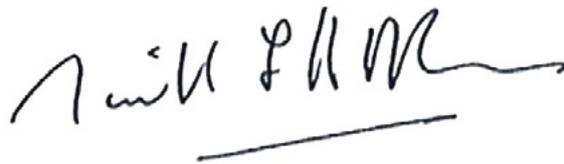
There is a recognition that we need to do everything we can to capture, spread and preserve this innovation, which means that while the next period will be a massive challenge, there are also significant opportunities. As part of our NHS Reset campaign, we have been engaging with health and care leaders, politicians, partner organisations and others to help shape the debate on the health and care system in the aftermath of the pandemic.

All this, however, is set in the context of the enormous challenge facing a system in which a significant proportion of staff are exhausted; which is facing an unprecedented backlog of treatment; and which is attempting to resume services with the spectre of further outbreaks and with restrictions around social distancing and infection control, which severely reduce productivity.

For this report, we have interviewed NHS trust chief executives. Their insights give us a glimpse of how we might see the health and care system in the future but also enables us to reflect on the remarkable way the NHS has responded.

I would like to thank the chief executives for their openness in sharing their personal and professional reflections with us. They are all part of the NHS Confederation's peer support programme for first-time chief executives – around 50 trust chief executives have taken part in the programme since it started in 2016.

This report provides insight into the experiences of senior health leaders who found themselves in charge of highly complex organisations at a time of national emergency, when all eyes were on them and their teams to prevent an even greater catastrophe. It highlights the many positive changes that came about which need to be built upon as we step tentatively to a new normal.



Contributing chief executives



Brendan Brown
Airedale NHS
Foundation Trust



James Devine
Medway NHS
Foundation Trust



Maz Fosh
Lincolnshire Community
Health Services NHS Trust



Dr Susan Gilby
The Countess of Chester
NHS Foundation Trust



Siobhan Harrington
Whittington Health
NHS Trust



Sam Higginson
Norfolk and Norwich
University Hospitals
NHS Foundation Trust



Janelle Holmes
Wirral University
Teaching Hospital
NHS Foundation Trust



Fiona Noden
Bolton NHS
Foundation Trust



Steve Russell
Harrogate and District
NHS Foundation Trust



Jonathan Warren
Norfolk and Suffolk
NHS Foundation Trust



Angie Smithson
Chesterfield Royal Hospital
NHS Foundation Trust



Sarah Tedford
The Hillingdon Hospitals
NHS Foundation Trust



Simon Weldon
Kettering General Hospital
NHS Foundation Trust

Summary

“We’re part of a system, not an island.”

Siobhan Harrington

The NHS Confederation runs a programme for first-time NHS chief executives in acute, community, mental health and ambulance trusts. The programme provides peer support and an opportunity for new chief executives to come together to discuss key issues. This report is based on interviews with 13 provider trust chief executives in which they discuss the changes they have made to respond to COVID-19, as well as how best to restart and deliver services as we move into the next phase of the pandemic. The interviews took place in late May and early June 2020.

The chief executives all felt that COVID-19 has had a major impact on the way providers operate. Siobhan Harrington felt “there has been a real difference in what providers do and how we do it.”

There was strong recognition of the impact COVID-19 has, and will continue to have, on communities and a desire to focus on population health, both in the way providers work as part of integrated care systems and also in the way the NHS is regulated and funding is apportioned.

There are huge challenges in health and care because of COVID-19 and concerns about the long-term impact on staff and the wider population. But there has also been considerable progress and innovation, and a sense of greater partnership working. As we reset, chief executives reflected that in the aftermath of the pandemic there is an opportunity not to return to the way we worked previously.

Several key themes emerged from the interviews:

How to reset and restart

All 13 chief executives emphasised the need and desire to not go back to how things were done previously. However, they were concerned about the potential long-term impact on staff and the challenge of continuing to operate COVID-19 services while also restarting routine services. The ability to restart safely was a key concern, including staff safety and patient and public safety. There was a recognition that the impact of COVID-19 and the economic impact and widening of health inequalities will increase pressure on the NHS in the future. They are concerned about rising health inequalities but also pragmatic about the potential opportunities for the NHS to support their local community.

Staff wellbeing

Dealing with the effects of COVID-19 has been extremely taxing on the NHS and its staff, both physically and mentally. The chief executives acknowledged and appreciated that staff were going above and beyond but were concerned about the long-term impact on their health. Concerns were expressed about staff wellbeing given the increase in reported levels of anxiety and fatigue during the pandemic. The concerns around staff wellbeing were heightened in trusts with a high proportion of black and minority (BME) staff, as evidence has suggested that those from BME backgrounds have been disproportionately affected by the virus. For many of the chief executives, a huge focus has been put on supporting their staff through the pandemic and beyond.

Sustaining and building on innovation

COVID-19 has seen huge innovation in the NHS, and the need to sustain and retain this was felt by all chief executives to be important. The pandemic has enabled trusts to execute many of the innovations they had been working on and planning for some time. The main change experienced by all trusts was an advancement in digital use. Prior to COVID-19, many had plans to expand their use of digital care and telemedicine, including virtual consultations, but the pandemic accelerated this. There has also been a wide range of innovations in how trusts operate with partners and in the flexibility of the workforce.

Partnership working

Working with partners across health and care was seen as vital in supporting the NHS to deal with COVID-19 and critical going forward. New chief executives felt that the provider sector has been overly focused on organisational form in the past and that the way providers have worked through COVID-19 has been a catalyst to system working, and has accelerated conversations about integrated care systems (ICS). The chief executives felt that the changes made through the Coronavirus Act have enabled greater flexibility in the way health and care services work together and that the removal of funding barriers has supported joint working. They welcomed these changes and felt that making them sustainable would support greater flexibility in the way health and care work together in the future.

Systems have also had a strong role in the response to COVID-19 and many felt that this period has accelerated the development of ICSs. But some chief executives felt that the lack of legislation to support their role meant that we have defaulted to an organisational response to COVID-19 rather than a system-led response. They also reflected on the role of commissioning during this time and felt that the move away from a transactional relationship was positive and that the role of commissioning and commissioners would need to change in the future.

The changing role of regulation and governance

The role of NHS England and NHS Improvement (NHSEI) was largely seen as supportive, but there were concerns over the assurance and necessity of required information, as well as differing views on the role of NHSEI regional teams. The chief executives interviewed want to see a change in how the Care Quality Commission operates and recognised inspections cannot return to their previous form, particularly given the ambitions to work as systems.

Making the best use of money

Chief executives felt that with the UK unlikely to emerge from COVID-19 soon there would need to be a new financial strategy for the NHS. Funding changes due to COVID-19 were largely viewed as positive, but there was concern that these changes were short term and do not deal with the underlying financial challenges NHS trusts face. Chief executives felt that funding needs to shift to incentivising a population health approach rather focusing on organisational health.

The future of the health and care system

1. How to reset and restart

As the number of COVID-19 positive patients in hospitals begins to decrease, chief executives and senior management teams are starting to focus more on resetting and restarting services following the emergency response to the pandemic. The chief executives interviewed for this report unanimously agreed that the road to recovery will be challenging for trusts and staff.

All 13 leaders were crystal clear that resetting is not about returning to life as it was pre-COVID-19, but instead moving forward to a new way of working. As Brendan Brown, chief executive of Airedale NHS Foundation Trust, put it: "It's all about how we support people, because life isn't going to return to life how we know it."

Fiona Noden, chief executive of Bolton NHS Foundation Trust, only took up the post on 1 April 2020 and has not experienced how the trust operated before the pandemic struck. But for her, reset is about the future rather than a return to business as usual: "It's not about calling it the new normal; it is more about how we want to function in the future."

The cohort identified three key concerns in resetting: staff wellbeing, restarting other NHS services safely, and the long-term impact on health inequalities.

Staff wellbeing

"COVID-19 is here to stay – how do we support staff over an elongated period of time?"

Sam Higginson

Staff wellbeing was cited as a major concern for all chief executives, particularly as we move into the next phase of the pandemic. Each leader spoke of their appreciation for staff going above and beyond to deal with the crisis, causing a positive change to the psychological contract.

Yet the mental health of staff was repeatedly raised as a key concern. All healthcare workers, not just those in clinical roles, have experienced and adopted different ways of working. There are concerns over the impact this has had on their mental and physical health.

High levels of anxiety and fatigue were reported by all trust leaders, but particularly those with a high proportion of black and minority ethnic (BME) staff, who felt extremely anxious. There was concern about BME colleagues and inclusion, particularly given evidence on the disproportionate impact of COVID-19 on BME groups. Several chief executives reported discussions with senior management teams on measures that could be put in place to allay anxiety, such as wellbeing sessions, and ways to support staff during these trying times.

Chief executives cited concerns about the long-term mental health impact on staff and many had prioritised mental health support within their trust. In Lincolnshire, for example, Maz Fosh, chief executive of the community healthcare provider, has worked with the wider system to enable staff to access support, ensuring that everyone has an outlet to call, if needed. The way the system has worked together has ensured consistency in messaging to staff, with each individual organisation tailoring messages to suit their organisation's style. This joint way of working has been highly positive.

Steve Russell of Harrogate and District NHS Foundation Trust has found that the support staff need is not isolated to events at work and has deployed psychologists from within the trust to support staff. Initially, this was concentrated on COVID-19 wards, but they recognised the need to extend provision. Staff may need support because of pressures outside of work, given the challenges of juggling family life, childcare, work and relationships. As such, the trust is taking a holistic view of the offer to staff, recognising that pressures may not be entirely related to working with COVID-19 patients.

Medway NHS Foundation Trust has worked with the Army, looking at what needs to be done mid-pandemic and what needs to happen in its wake. The trust is focused on ensuring that it is overt in the support it offers and works with staff to find out what they want and need.

For Jonathan Warren of Norfolk and Suffolk NHS Foundation Trust, the experience has been slightly different. As a mental health trust, there is a sense that “the peak hasn’t happened yet.” The mental health and learning disability services provider is expecting an increase in demand and recognises that there will be a number of staff working with COVID-19 patients from other trusts that will need mental health support, as well as the wider population.

All chief executives raised that there had been increased communication in their trust – something that was well received by staff. Increasing communication, through webinars, Q&A sessions and email, allowed staff to feel reassured and updated on the work of the organisation, as well as engaging staff working from home and giving them a chance to raise concerns.

Leadership reflections

“The first word that comes to mind is ‘proud.’” James Devine

‘Proud’ and ‘humbled’ were often used when the chief executives talked about their staff over this period. Maz Fosh remarked on the way colleagues have stepped forward, “putting themselves front and centre of this horrendous virus.” Echoing the point, James Devine also acknowledged the personal sacrifices staff have made to care for patients. Fiona Noden, just weeks into a new job, has been overwhelmed by the response from staff and the way they have transformed services.

Janelle Holmes of Wirral University Teaching Hospital NHS Foundation Trust found communicating with staff to be vital, particularly in the early days of the crisis. Wirral was selected in January as the trust to treat patients repatriated from Wuhan, which created a lot of anxiety for staff during a challenging time. In the initial stages, Janelle was holding daily staff briefings along with the medical director to respond to questions and help manage anxieties. Once social distancing was introduced,

that had to shift to online communications, with Janelle holding live digital sessions. Encouraging staff to raise concerns and having an honest dialogue helped to manage staff anxieties and has been widely appreciated.

There was also a recognition that staff have had access to a wide range of benefits during this period, with trusts providing free parking, increased wellbeing support, hotel stays and free food. Additionally, there has been overwhelming support from the public and companies. It was acknowledged that “the small things matter too – COVID-19 has brought this back in the NHS.”

Whittington Health NHS Trust in London has been working with Project Wingman. The project involves people in the airline industry setting up a first-class wellbeing lounge in the hospital for staff, giving them a chance to decompress and unwind – staff have really welcomed this support.

Generally, there was a feeling that many staff are currently working on adrenaline and it will not be long until fatigue sets in, which will cause further challenges. As trusts move into the next phase of the COVID-19 response, the leaders we spoke to felt it imperative to continue to support staff.

Restarting safely

“We will never be what we were before.”

Siobhan Harrington

Restarting services was said to be an interesting challenge as “there will be a new normal and different people, both staff and public, will process it differently.” Despite the differences in how to restart and what the challenges would be, it was accepted that the most important thing would be to do so safely.

Using experience from previous pandemics, some trusts had members of staff focusing on recovery and reset from the outset of the pandemic. The Countess of Chester Hospital NHS Foundation Trust, for example,

has a senior management team with clinical backgrounds. Dr Susan Gilby noted that due to this, they were able to use their clinical knowledge to start planning ahead and put measures in place to deal with both the pandemic and its aftermath.

For the leaders interviewed, the concept of restarting safely covered staff safety, patient safety and the general operational safety of the trust. For staff, we heard that it will be imperative that they have the support and resources they need, including psychological support, personal protective equipment (PPE) and testing. Concerns around PPE and testing varied among the chief executives, with some believing they had enough while others remained uncertain. Some also cited testing as an area that had not worked well under national control and where the role of local leaders could have been greater.

There were also concerns about keeping the physical workspace and workforce safe. Many chief executives expressed concerns over how to encourage socialisation while being mindful of social distancing. And in terms of clinical areas, where both the public and staff meet, how to operate in a safe way.

For patients, it is vital that they feel safe to access healthcare when necessary. During the initial response to COVID-19, statistics showed a decrease in emergency attendances and access to health services. There are growing concerns that health inequalities will increase further as a result. Several of the leaders stressed the importance of making sure patients and the general public are kept up to date on the latest government advice on care and surgeries, as well as how to manage their health on their own, especially as the delay to some elective surgeries is expected to go on for some time.

Reinstating the full amount of elective surgeries will be difficult and some chief executives spoke about the likely need to continue to work with other trusts to deliver services:

“We may need to come to an arrangement with other trusts in the area about how we manage services effectively.”

Steve Russell

The role of the system in restarting services safely was also discussed. Angie Smithson of Chesterfield Royal NHS Foundation Trust highlighted the need for consistency in the system and providing consistency for patients across Derbyshire – this is something they are currently working through.

Health inequalities

“COVID-19 is like sand: it has touched everybody in one shape or form, it gets in the crevices of our lives and we can’t escape it.”

Brendan Brown

COVID-19 has exacerbated health inequalities and all 13 chief executives were apprehensive about the impact it will have on local communities, particularly given a recession on the horizon with far-reaching economic impact.

“Hospitals are anchor institutions for our communities. We have a bigger role to play in the future than just providing healthcare.”

Brendan Brown

The NHS has a unique role in supporting its local communities and is more than just a healthcare provider: it is a large employer with a significant number of vacancies. While being concerned about the impact of COVID-19 on communities, the chief executives also saw the potential for their trusts to do more to support local populations. Sarah Tedford of The Hillingdon Hospitals NHS Foundation Trust is keen that the trust becomes the hub of the community. The trust is working closely with the local authority to explore how it can support the local community to deal with the impact of COVID-19 – including potentially setting up a food bank, supporting local employment and supporting people experiencing homelessness in the area.

Angie Smithson has seen a change in the way the trust supports patients locally. During the emergency response to COVID-19, a patient required an urgent ophthalmology appointment but was concerned about driving. The GP worked with a local voluntary group to arrange a driver to take him to his appointment. There are a number of examples of how

organisations across health, social care and the third sector are working with partners to look at how they can deliver services for the whole population shaped by the user voice.

Brendan Brown reflected on the need to have an honest conversation with the public about the use of the healthcare system. "There is a need to let communities lead and manage their own lives, while having a conversation about what is deemed necessary to the healthcare sector and what is necessary to them."

The chief executives also expressed concern that mental health issues will be exacerbated in the community, especially in those from seldom-heard communities, those who have been shielding and those in higher risk groups.

Jonathan Warren is particularly concerned that the expansion of people accessing mental health services will impact exponentially on the most seriously mentally ill, and that by expanding services to deal with greater numbers of people accessing mental health services it could be at the expense of those who need it most.

2. Sustaining and building on innovation

COVID-19 has significantly changed the way trusts operate, with Hillingdon Hospital NHS Foundation Trust reporting to have implemented over 150 innovations – "some big, some minor, but all making a change." COVID-19 was seen as a chance for organisations to execute many of the innovations they had been working on and planning for some time.

Digitisation

The main change experienced by all trusts was an advancement in use of digital technology. Prior to COVID-19, several trusts had plans to expand the use of digital care and telemedicine, including virtual consultations, but the pandemic accelerated uptake.

Janelle Holmes of Wirral University Teaching Hospital NHS Foundation Trust reported that the trust “managed to deliver what they had planned to do in two years in two weeks.” Chesterfield Royal NHS Foundation Trust reported that only 4 per cent of outpatient consultations were done via telephone prior to COVID-19 and now 86 per cent are done by phone. They had the facilities in place, but the pandemic enabled them to deliver the change at pace.

James Devine spoke of the need for a transformational mindset rather than reverting back to how things were before and raised the challenge of maintaining the innovations that have happened without some central coordination.

The way services are accessed has also changed and patients are now advised to call their GP or 111 before attending A&E or urgent treatment centres. This is an innovation that many chief executives have found positive and would like to retain. They also reported that they were able to work well with local GPs and partners using digital systems, such as e-referral forms.

Despite the vast number of positive remarks around digitisation, there are some areas where digitisation did not work. Steve Russell recounted a clinician saying: “I never want to do an unnecessary outpatient appointment again, but I also never want to tell a patient that they have terminal cancer on the phone again.” This reinforces the balancing act of evaluating change. Simon Weldon of Kettering General Hospital NHS Foundation Trust echoed this point, saying that we should not presume to know what changes staff want to “treasure, trash or polish.” He told of his surprise when having a conversation with staff over the range of things they raised.

Chief executives felt that further work is needed to ensure that the digital innovations that have been put in place are effective long term and are sustainable.

Flexible working

All trusts have made an improvement in flexible working, particularly in enabling more staff to work from home. The use of technology within trusts to support different ways of working has enabled greater flexibility and has been positively received.

Although flexible working has had a warm reception, the choice should be based on individuals' needs: "some people need the community and to be around people when they work." Many of the chief executives highlighted that if remote working is to become the norm, they would need to establish ways of ensuring that staff continuously have the support and access to management they would ordinarily have in the work place. As mentioned earlier, the increased communication from senior staff, through calls, webinars and emails, has been positively received and is something that would need to continue if there is to be lasting change in the way staff work.

Returning staff and redeployment

Concerns about staff shortages due to COVID-19 meant that some returned from retirement to assist with the pandemic, some student healthcare professionals started working early, and in other cases staff were redeployed to different areas, sites and into care homes. This proved useful for many trusts and was positively received by staff, as it allowed them to work more flexibly, furthered experience and enabled training in areas they would not otherwise have had.

This is a welcome change that many trusts would like to keep, as it has helped alleviate some recruitment issues. But it is important to acknowledge that the methods used to recruit and redeploy may need to be revisited to ensure that they are effective long term.

3. Partnership working

“The joy is that patients are at the heart of it.”

Jonathan Warren

Jonathan Warren reflected that there has been a relentless focus on patients during this period and that organisations were working together in a way that was far more meaningful. The relationships between providers, clinical commissioning groups, local authorities and the voluntary and community sector has accelerated and there has been a wider population-based focus.

The quality of the discussion has also been remarked upon, with an evolution in the conversations systems are having and the right people getting involved. As a result, they have been able to progress far quicker and deal with issues more effectively. While overall the pace of change has been refreshing, some chief executives also raised concerns that a number of changes are happening too quickly and might not have the necessary buy-in. Sarah Tedford pointed out that: “we don’t want to move too quickly without buy-in and careful consideration.”

“During COVID-19 many of the hoops we normally have to jump through have been removed and the focus has moved from transactional discussions to focusing on wellbeing, outcomes and inequalities.”

Steve Russell

System working

“COVID-19 has reinforced the need to resolve the ICS legal position if we are to work in different ways going forward.”

Sam Higginson

Despite not having operational responsibilities during COVID-19, we heard from chief executives that systems have played a strong role. While some of the existing system architecture has been paused, many new ways of working have developed. Chief executives felt that the legal

construct of systems needs to be strengthened moving forward and that the lack of legal structure for integrated care systems (ICSs) has resulted in defaulting to organisations leading the COVID-19 response rather than systems.

The existing development of system infrastructure has enabled people to work together through the mechanisms that were in place. Systems that previously were 'immature' in their development have accelerated their working throughout the pandemic. Their development towards becoming an ICS has progressed in such a way that some felt it arbitrary to view it as part of a framework when "it's a way of being."

The chief executives saw a role for greater autonomy and "the freedom to act and work at pace without contracts getting in the way." Some reflected that they were optimistic for the future and that while there will be greater collaboration, there will still be a strong role for providers as we reset.

The reflections demonstrate a shift from an organisational focus to system working, and a move away from contractual and competitive relationships to increased local decision making.

The role of commissioning

"We need to move away from a transactional way of commissioning; commissioning needs to be much more clinical outcome based than the way it usually is."

Susan Gilby

The role of commissioning and commissioners has changed during COVID-19 with NHS England and NHS Improvement exercising some CCG powers and CCGs working in different ways to support providers.

Leadership reflections

As with staff across the sector, chief executives too have felt the effects of the pandemic. Fiona Noden, who started her tenure as the pandemic struck, is yet to have a formal corporate induction but has been absorbed into the organisation and is working in a way she could never have previously imagined.

The resilience of leaders in dealing with the unknown should not go unrecognised. Several reflected on needing to change their leadership style and adapt to the challenges of not being visible in a way they normally would. For Steve Russell, the enormity of leading an NHS organisation at a time

of crisis has manifested in a wide range of emotions, from worried and scared to inspired and proud. But he considered the role a privilege.

Despite the challenges of this period, several leaders also reflected on the benefits. Sarah Tedford found that it has brought out the best in team working, not just within her organisation but across the wider health and care system. She felt privileged to be part of it.

The leaders also recognised that their role may change in future and that there is an opportunity to redefine the NHS.

Siobhan Harrington observed that during COVID-19 commissioning has not been needed in its previous transactional form and there was a need to consider what the role of commissioners would look like in the world that emerges after COVID-19. Similarly, Susan Gilby felt that there was still a need for clinical commissioning but that it may need to be in a different form than existing CCGs. This point was echoed elsewhere, with some chief executives stating the need for more strategic commissioning sitting at a system level.

Working with local authorities

Broadly, the chief executives felt that relationships with local authorities have been positive during this period, with the NHS and local authorities working well together. In some areas they had worked collaboratively, sharing PPE, working on discharge and flow together and supporting care home leads to offer support to their workforce. Prior to COVID-19, many of the trusts had good working relationships with their social care system and local authorities. In many cases, these relationships were improved during the pandemic. Several trusts reported smoother discharges and fewer delays.

System working has continued to support that engagement in some areas, with regular calls across the system, including local authorities.

While relationships with chief executives have been strengthened, many felt that this was, in part, due to changes in the financial and legislative framework. The Coronavirus Act 2020 came into force on 25 March 2020, making extensive changes to the powers and duties of local authorities. Chief executives felt that these changes, and changes to the flow of funding, removed some of the barriers to the way health and care work together and enabled greater joint working. They were keen to see these changes sustained into the future and for there to be greater alignment between health and care.

Wider partnership working

The chief executives also spoke about how they have worked with other partners in their system and the way COVID-19 has changed and developed relationships. This was notable in how the independent sector has worked with the NHS over this period and was identified as something the leaders felt should be explored in the future.

Similarly, the engagement of primary care was mentioned by several chief executives. Fiona Noden has seen greater collaboration with primary care, and changes to the way they work has meant GPs are now thinking about what they want for primary care networks (PCNs) to really work. They have created a new managing director role as a joint

appointment between the trust, the local authority and the PCN. Sarah Tedford has also found the support from primary care to have been extremely strong during this period. This view was not universally shared, with some chief executives commenting that primary care in their area had been “silent” and had “stepped back rather than stepping up.”

4. The changing role of governance and regulation

“I’m a big fan of governance but sometimes it stifles things.”
Sarah Tedford

Chief executives largely felt that COVID-19 has enabled things to happen at pace. The cohort felt that as we move forward, it will be important to look at what is needed and to be smarter with how governance is managed. They were keen to stress that the light touch nature of regulation during this period does not mean that governance was forgotten – rather, it empowered people to make decisions quickly. As Maz Fosh made clear: “Clinicians and senior leaders are not going to jeopardise the quality of care for patients – what we need to see now is lighter touch regulation and inspection.” Allowing them the freedom to deliver change has enabled them to deliver lasting improvements for patients.

The chief executives felt that trust has been key during this period. Rather than returning to the previous burden of regulation and paperwork, there needs to be a greater balance and focus on building an open and transparent culture and leaving trusts to make decisions, so long as the outcomes are clear and patient and staff focused.

Role of NHS England and NHS Improvement

The majority of chief executives felt that NHS England and NHS Improvement (NHSEI) had been supportive and have had regular engagement with providers during this period. They commented that the messaging from Sir Simon Stevens and Amanda Pritchard was helpful and that there is a greater dialogue and a greater emphasis on

discretion and trust. The role of the chief operating officer, Amanda Pritchard, was commented on as particularly useful: “she has worked collaboratively with trusts, listening to leaders and asking chief executives to lead on national challenges.”

While the relationship with NHSEI has been largely seen as helpful, the role of government ministers was viewed less favourably, with public messaging often not reflecting the situation on the front line.

There was concern that as we move forward, old behaviours were starting to creep back in and that assurance will get worse and more time consuming. Some reported that this has already begun. Chief executives reported multiple requests for information on restarting services, often with short timescales and a lack of clarity on how the information would be used.

There were differing perspectives on the role of the NHSEI regions. Some felt that they did not have much of a role, there was a lack of clarity about their purpose and were “parroting what they have been told nationally.” Some felt the emergency planning, preparedness and resilience role was not well prepared and that there is a need to look at the capability and capacity the NHS needs to deal with an incident of this nature in future. Others felt the region had played a helpful role in keeping everyone connected.

In London, it was felt that the speed with which COVID-19 hit meant that trusts were often operating ahead of national guidance being available. Siobhan Harrington felt that the NHSEI region had played a significant role in the way the capital responded, and with the focus on the development of the Nightingale Hospital, it enabled local systems to take responsibility and get on with delivery.

The Care Quality Commission

After calls from the NHS Confederation, the Care Quality Commission (CQC) paused inspections in March. While the majority of chief executives found this has been helpful, we also heard that for organisations due an inspection it has been disappointing, as it has not enabled them to show the progress they have made.

Chief executives largely felt that CQC inspections cannot return in the way they were conducted previously. Simon Weldon felt that there was a need to look at what intelligent regulation might look like and, that with waiting lists at an all-time high, it would not be possible for the CQC to assess services in the way it had previously. Fiona Noden reflected that there was a place for the CQC but that its role may need to be re-thought. She felt that in the future it needs to focus more on patient pathways and should be more reflective of patients' views rather than taking such an organisational focus. Similarly, Janelle Holmes said there is a need for senior clinicians and NHS leaders to have greater involvement in and the ability to influence the future inspection regime.

Some raised concerns about the circular nature of regulation and felt it was too responsive to individual events and incidents which spark increased regulation. They felt that it needs to be a more ongoing strategic relationship.

They also felt there was a need for the regulator to be more than just individual organisations. Janelle Holmes, for example, discussed the way her trust delivers joint pathways and works with partners, with cross-organisational working increasingly playing a significant role in the delivery of patient care. As a result, she felt that the CQC's remit needs to go beyond individual organisations and look at the role of the system, considering the way services within individual trusts are influenced by others.

5. Making the best use of money

During the immediate response to COVID-19, trusts that were not already on block payment contracts moved to the arrangement from the previous payment by results model. The block contract model has been extended until the end of 20/21 financial year. Chief executives whose trusts were not previously on block contracts welcomed the change and felt that the reduction in transactional arrangements was important. But there were concerns over a reversion to previous arrangements.

While the writing off of historic debt was welcomed by affected trusts, it was felt that it would not make a significant difference to their financial position, as it was not dealing with the ongoing financial challenges trusts face. There were concerns about finances going forward and gaps in the infrastructure, particularly with the economic downturn and with the changes required to respond to COVID-19. Added to that, there were concerns that the infection, prevention and control measures needed to respond to COVID-19 will have an estates implication and capital funding to respond to those changes, particularly for older estates, would be significant.

Chief executives felt that with the UK unlikely to emerge from COVID-19 soon, there would need to be a new financial strategy for the NHS. For Simon Weldon, there is desire to avoid reacting episodically to COVID-19, but to be strategic and have a strategy that does not put in more financial strictures. There were concerns about the potential for winter 2020/21 to be particularly challenging and the need to have a strategy for health and care for the rest of this year to support organisations to respond effectively.

As organisations increasingly work beyond their own organisational boundaries, it was felt that funding should encourage collaboration rather than competition between providers.

Jonathan Warren reflected this, pointing out the imperative for the financial regime to incentivise population health rather than organisational health. He also highlighted the need for funding arrangements to cover the wide range of needs the NHS covers and to ensure that the way funding is delivered does not leave behind the most seriously mentally ill. There was a clear desire among chief executives not to return to where we were before but to think strategically and recognise the challenges ahead.

NHS Confederation viewpoint

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The new chief executives interviewed for this report encountered similar experiences dealing with the COVID-19 outbreak, and as a result many of the changes they want to see, and those that have already been implemented, are similar.

Both providers and government have made changes to the way they function, which has allowed for a more agile working environment. However, it is vital to acknowledge the adverse impact that COVID-19 has had on both staff and the public, especially the potential long-term impacts on mental health and wellbeing, and health inequalities.

Some of the challenges raised in this report will not be easy to resolve, but it is important that the learning and perspectives are used as the NHS moves into the next phase of the response to COVID-19.

To echo the thoughts of the chief executives, we simply cannot go back to the old ways of working. This is the key focus of NHS Reset, our campaign to help shape what the health and care system should look like in the aftermath of the pandemic. Recognising the sacrifices and achievements of the COVID-19 period, it brings together our members and partners to look at how we rebuild local systems and reset the way we plan, commission and deliver health and care.

Find out more at www.nhsconfed.org/NHSReset

Biographies

Brendan Brown

Brendan was appointed in 2018 to the joint position of chief executive of Airedale NHS Foundation Trust and partnership lead for the Airedale, Wharfedale and Craven Partnership. He has previously held the position of executive director of nursing/deputy chief executive at Calderdale and Huddersfield and Burton Hospitals NHS Foundation Trusts. Brendan has a clinical and therapeutic background and a proven track record of improvements in the delivery of healthcare across hospital and community settings. He is the senior responsible officer for workforce across the Bradford and Airedale place and for the West Yorkshire and Harrogate Health and Care Partnership Board.

James Devine

James was appointed as the substantive chief executive of Medway NHS Foundation Trust in April 2019, having acted as interim chief executive since November 2018. He brings over 20 years' experience of working in the NHS, having started his career as an apprentice in Medway. He went on to work in organisations including South London Health Care, Barts Health and Great Ormond Street Hospital, before returning to Medway in October 2016 to take on the role of executive director of HR and OD. He was announced as the deputy CEO in November 2017, becoming interim chief executive a year later.

Maz Fosh

Maz has over 20 years' experience in workforce and human resource management both in the public and private sectors. Prior to joining Lincolnshire Community Health Services NHS Trust in February 2013, she spent three-and-a-half years in the acute sector, where she worked at both deputy director of HR and assistant director of HR level at United Lincolnshire Hospitals NHS Trust. She joined the NHS in 2009 after completing 14 years in the police service, where she held a number of senior human resource positions. Prior to this she was a personnel and training manager in the retail sector.

Dr Susan Gilby

Susan joined The Countess on 1 August 2018 as medical director before becoming acting chief executive in October 2018 and then the substantive chief executive in April 2019. Susan, who first had a spell at The Countess during her specialist training, has previously worked as medical director at Wirral University Teaching Hospital NHS Foundation Trust and Wye Valley NHS Trust and as associate medical director at Mid-Cheshire Hospitals NHS Foundation Trust.

Siobhan Harrington

Siobhan has been chief executive of Whittington Health since September 2017. Previously deputy chief executive and director of strategy at the trust, she also held the role of director of primary care from 2006. A nurse by background, Siobhan has extensive experience at national, regional and local level. She has held positions with the Department of Health and the National Primary Care Development Team. Siobhan has previously held the roles of director of primary care at Haringey Primary Care Trust and programme director for the implementation of the clinical strategy for Barnet, Enfield and Haringey. clinical strategy for Barnet, Enfield and Haringey.

Sam Higginson

Sam was appointed chief executive of Norfolk and Norwich University Hospitals NHS Foundation Trust in October 2019. He joined from Cambridge University Hospitals NHS Foundation Trust where he was chief operating officer from March 2017. Previously director of strategic finance for NHS England, he was director of strategic development at University College London Hospitals NHS Foundation Trust between 2010 and 2013. Sam started his career at UNICEF as a UN logistics officer. He joined NHS London in 2008 after four years on the HM Treasury Health Spending Team and prior to that was a management consultant. Spending Team and prior to that was a management consultant.

Janelle Holmes

Janelle was appointed chief executive of Wirral University Teaching Hospital NHS Foundation Trust in June 2018, having already spent two years at the trust as chief operating officer. Janelle has worked in the NHS since qualifying as a registered general nurse in 1991. She is passionate about service improvement, staff development and whole system working to improve patient outcomes and experience.

Fiona Noden

Fiona was appointed chief executive of Bolton NHS Foundation Trust in April 2020. She started her career in health as a radiographer and has extensive clinical and management experience in operational management, project management, organisational strategy development and deployment. Fiona moved from clinical radiology into operational management in 2006 as the divisional director of operations at Salford Royal. She went on to become director of operations and performance at Wrightington, Wigan and Leigh. Before joining Bolton, she spent five years as the chief operating officer at The Christie. She is dedicated to delivering continuous improvements and providing an inclusive environment for staff.

Steve Russell

Steve joined Harrogate and District NHS Foundation Trust as chief executive in April 2019, having been regional director for London at NHS Improvement. He joined the national management trainee scheme in 1997 and has spent most of his career in the provider sector in operational roles. Prior to his time at NHS Improvement, Steve worked as chief operating officer at South London Healthcare, was programme director and improvement director at the NHS Trust Development Authority and spent two years as deputy chief executive at Barking, Havering and Redbridge University Hospitals NHS Trust. Steve spent his first 14 years at Northumbria Healthcare NHS Foundation Trust.

Angie Smithson

Angie has been chief executive of Chesterfield Royal Hospital NHS Foundation Trust since September 2019. She has more than 30 years' experience and began her career in nursing and midwifery in 1986, before moving into a range of leadership positions. Angie moved back to the Midlands after spending five years based in Liverpool as a deputy chief executive/chief operating officer. Between 2017 and 2019, she combined the deputy role with the dual responsibilities of integration director, leading a complex and challenging merger to combine Aintree University Hospital NHS Foundation Trust with the Royal Liverpool and Broadgreen University Hospitals NHS Trust.

Sarah Tedford

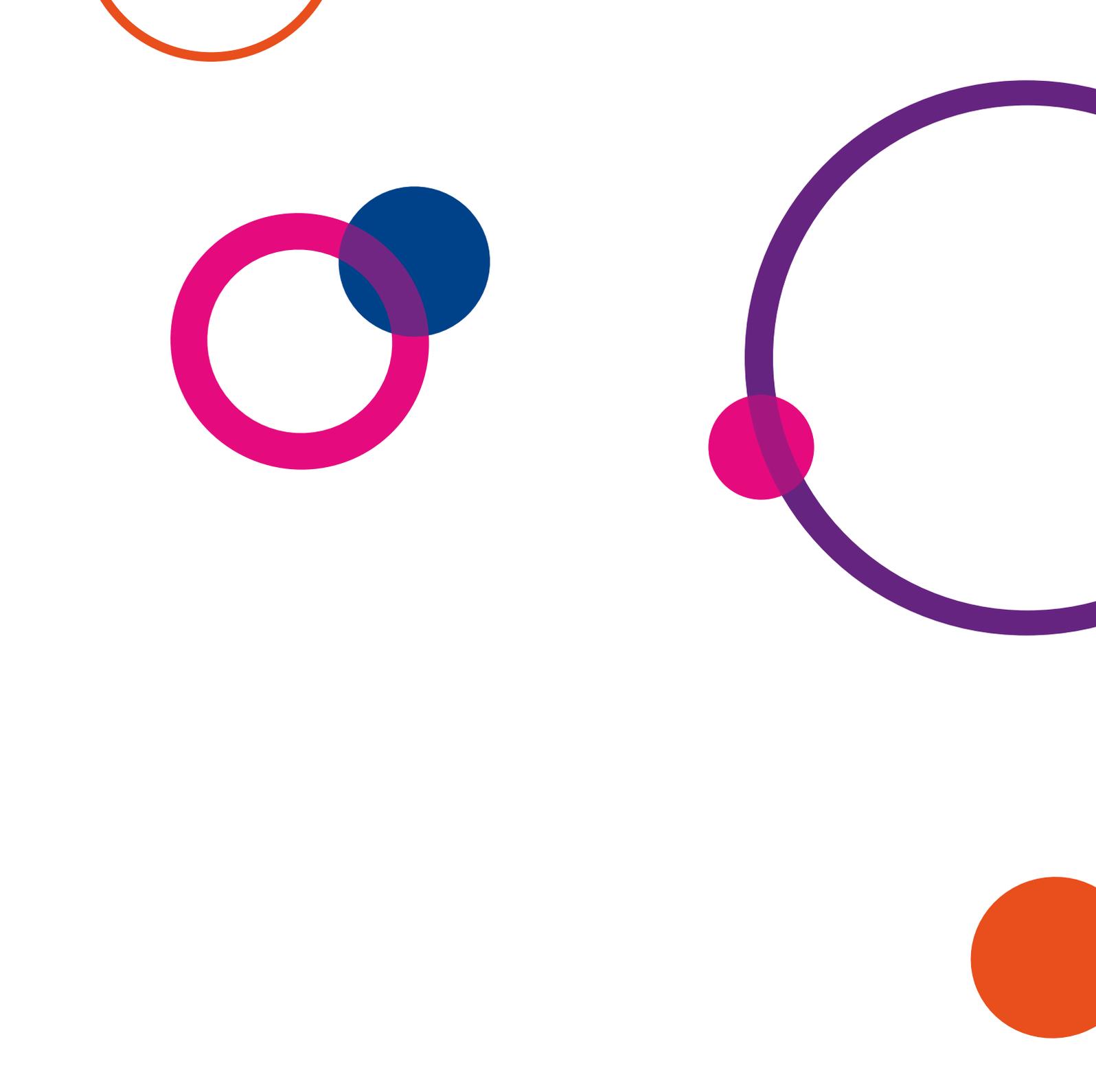
Sarah was appointed chief executive in November 2018. She joined from Manchester University NHS Foundation Trust where she had been chief executive since March 2018. Prior to this, Sarah spent the six months on secondment to NHS England and NHS Improvement as winter director for London to provide assurance on the systems and processes monitoring delivery of the national A&E standard across London. Previously she was chief operating officer at Barking, Havering and Redbridge University Hospitals NHS Trust, helping the trust to exit special measures. Prior to that, Sarah held the deputy chief executive role at Kingston Hospital NHS Foundation Trust.

Jonathan Warren

A senior manager and clinical leader with over 35 years' experience in a variety of healthcare settings, but predominantly within mental health, Jonathan has previously worked as deputy chief executive and chief nurse for Surrey and Borders Partnership NHS Foundation Trust. This included ten months as acting chief executive. Before that, he occupied a similar role at East London NHS Foundation Trust. At both trusts, Jonathan led the work that enabled both organisations to improve their CQC rating. At East London, this led to the trust becoming the first combined mental health and community health services trust to achieve 'outstanding'.

Simon Weldon

Having served as chief executive of Kettering General Hospital from April 2018, Simon was appointed group chief executive for both Northampton and Kettering General Hospitals in July 2020. He joined from NHS England, where he held the posts of director of operations and delivery and, formerly, regional chief operating officer. He was responsible for overseeing the CCG regulatory regime, heading up the emergency planning function, supporting the urgent and emergency care transformation programme, and leading the information function across NHS England. Specialising in acute contracting and operational performance, Simon also has significant experience in public health, primary care and specialised commissioning.



NHS CONFEDERATION



The **NHS Confederation** is the membership body that brings together and speaks on behalf of the whole NHS.

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