Good Governance in times of 2020 crisis

COVID-19
Board assurance prompt

1 April 2020
Good Governance Institute

What is this guide and who is it for?

This briefing is for chairs and non-executive directors of NHS provider organisations. It is intended to provide a high-level summary of some of the principal challenges related to the COVID-19 pandemic, as well as a selection of key assurance questions boards should be asking themselves to assess the effectiveness of their response. In particular, it aims to help colleagues gain a rapid understanding of the key issues related to COVID-19.

What is COVID-19?

COVID-19 is an infectious disease caused by a newly-discovered coronavirus. The virus is mainly transmitted through droplets generated when an infected person coughs, sneezes or speaks. The virus affects the lungs and airways and typical symptoms include a cough, a high temperature, and in severe cases, shortness of breath. Most people infected with COVID-19 will only experience mild to moderate respiratory illness and will recover without hospitalisation. However, the risk of a severe response increases in older people, and those with underlying medical conditions.

COVID-19 was declared a pandemic by the World Health Organisation on 11 March 2020. By this point, the NHS had already declared COVID-19 a Level 4 National Incident and the UK Government had published its coronavirus action plan. Since then government and NHS leaders have gradually taken steps to curb the spread of the disease. This has included reinforcing simple actions that everyone can take such as practicing social distancing, as well as more formal measures such as instructing pubs, restaurants and many shops to close.

The nature and scale of the response depends on the course of the disease, which cannot yet be predicted accurately. The situation is changing constantly and will require an agile response.

Key challenges for the NHS associated with COVID-19

Workforce

Prior to COVID-19, the NHS was already facing stark workforce shortages. The pandemic will severely stretch our dedicated and hardworking NHS staff. Retired NHS staff have been asked to return to work, and more than 750,000 volunteers have been found to help vulnerable people stay safe and well at home. Recent guidance has also indicated that medical and dentistry trainees, as well as those with dual qualifications, may be asked to work in different clinical areas or even in a different provider within their local healthcare system in order to meet increased demand, though essential services will be protected whether in acute, mental health or community. Similarly, some non-clinical staff may be asked to support primary care and other providers.

The response to these measures has been heartening, however new and returning staff will require help to ensure that they are able to hit the ground running and to practice safely. Staff being asked to act up, or manage small teams during this period will also need to be supported and encouraged.

Health Education England has developed a programme of webinars to support returning staff, and NHS trusts will also want to ensure that they have put in place their own measures to support those transitioning back to work or into new roles.

Health and wellbeing

COVD-19 is the biggest challenge the NHS has ever faced. During this difficult time, the health and wellbeing of NHS staff is of paramount importance. Many have already expressed apprehension about returning to work and over the safety of current working conditions – a view reinforced by a recent survey of NHS trust chief executives which revealed that workforce shortages, a lack of staff testing and running out of PPE were their three biggest concerns. It will be vitally important, in the coming months, that staff feel listened to and that they see that their concerns are being acted upon.

The government is taking measures to ensure that NHS staff will have access to COVID-19 tests and to PPE, although these have been slow to materialise. During this period, boards will therefore want to be mindful that they communicate and engage effectively and regularly with existing staff (using mixed methods); that measures are in place (as much as possible) to safeguard staff health, safety and wellbeing; and that avenues are being appropriately explored to increase capacity whether through partnership working, encouraging recent leavers or retired staff to return, or redeploying existing staff. Board member visibility will be essential, especially to ensure that those unable to work remotely do not feel left behind.

The impact on staff of having to travel to and work in unfamiliar settings should also not be underestimated. The NHS Confederation has published useful guidance on its website to support workforce and HR leaders in this endeavour.

NHS organisations need to support staff, wherever possible, to work from home. Additional focus will be needed to enable staff to engage with colleagues and to not feel isolated when working remotely.

Partnership working

At this time of national crisis, NHS organisations, other public services, and local business will need to work in partnership. NHS boards need to think innovatively, not only about how they maintain quality and safety within their own organisations, but also within their local partners and broader stakeholders. This may require increased engagements to accelerate partnerships that may have been in their early formative stages. Now is truly the time for boards to think system by default.

Numerous examples of effective joint responses to COVID-19 are already emerging. For instance, the NHS recently reached a landmark agreement with the Independent Health Providers Network to secure all available inpatient capacity and resource in every area in England. NHS trusts are following Joint Emergency Services Interoperability Principles to ensure that emergency service responses are aligned. And, local and national businesses are working hard to supply NHS staff with food and supplies.

Taking a longer-term view, relationships that are established and fostered during this period must be maintained and harnessed to advance the integrated care agenda in the future.

Evolving models of care

There is an urgent need to rapidly increase intensive care capacity as hospitals see a surge in demand as a consequence of COVID-19. The NHS has now revised its guidance on staff-to-patient ratios for intensive care: from a 1:1 intensive care nurse-to-patient ratio to 1:6, and from a 1:8-1:15 intensive care consultant-to-patient ratio to a 1:30. It is hoped that, alongside the increased supply of emergency equipment and the redeployment of staff, this will help ensure that intensive care units are adequately resourced to meet demand. However, concerns have been raised and persist over patient safety.

NHS trusts are also exploring opportunities to expand the number of intensive care beds available to patients. This has included through the repurposing of beds that would otherwise be used for more routine care and looking at alternative estate from within which to deliver care, as with the Nightingale Hospital in London. It will be important that local surge plans for main care pathways describe how they will both scale up and segregate services to respond to demand, and that plans for other services explore how they are able to support these. NICE guidance on critical care will be useful when crafting these plans.

While these measures are necessary, NHS boards will need to be sensitive as to how new sites are resourced and also to the increased mental and physical pressures that revised staff-to-patient ratios will place on their staff and patients and ensure that the quality governance processes continue to work effectively.

Embracing digital

The COVID-19 pandemic is fast tracking behavioural change that might previously have taken many years to embed. For example, we have seen a significant uplift in the use of digital consultations within primary care.

While digital technology has the potential to dramatically increase access to, and the quality of, care, it can also require staff to work in new and different ways. We have previously published our thoughts on the implications of moving board and other meetings online during this time, and provided guidance on the adoption of a new etiquette and behaviours. Across the service there must also be a recognition that technology often takes time to become properly embedded and for staff to begin to take accountability for its use. Boards will need to monitor the implementation of digital solutions, offer adequate support and training to those staff who will utilising it (including to those working remotely), and ensure that there is no patient harm as a consequence of its introduction.

Governance

The government has made clear that the NHS will have the financial support it needs to respond to COVID-19, and rightfully substantial amounts of management time will be devoted to ensuring that the NHS response is coordinated and effective. However, there is a risk that quality governance and oversight is neglected as attention is diverted.

At this point, it is important to remember that boards of NHS trusts remain the controlling mind of their organisations, and are ultimately accountable for their effective operation. Boards should continue to meet, not least because it will ensure that NED expertise is maximised and that they are best able to support executive teams. NEDs now more than ever are the 'guardians of governance'.

Boards will want to be mindful of their statutory duties but equally they must be conscious of, and receptive to, the expectations that their staff, stakeholders and communities will reasonably place upon them. This means requiring and receiving positive assurance not just on service preparedness and response, but also on clinical leadership, engagement and ownership of developing plans; on the health and wellbeing of staff; on proactive, meaningful and effective communications with staff at all levels (including those who may not have access to NHS email accounts); and, critically, on health and care system preparedness – a comprehensive NHS trust COVID-19 plan should be part of a system wide plan that shows how organisations will work together across sectors and geographies.

Agendas and cycle of businesses will need to be revised to accommodate this, reducing the length and burden of meetings, but also ensuring that things are not lost. Recent guidance indicates that (for obvious reasons) quality committees will need to continue, but there are opportunities to streamline or delay other committees.

Trusts will also want to be nimble and responsive to new ways of working. Many have already taken the opportunity to establish or refresh their ethics committees to reflect this.

The rest of this prompt

The rest of this prompt consists of a series of assurance questions that board members and others developing services might ask of themselves or the boards to ensure that the responses of their organisation are effective and appropriate. These assurance questions are examples only.

As with all our publications, we will revisit these as the situation evolves.

Question	What to look out for
Has the trust deployed its major incident procedures effectively?	Has the trust implemented a robust command and control structure to oversee and lead on the incident response plan? Does this include: • A single point of decision making and coordination that is appropriately resourced and coordinated • A standard structure and approach to management that enables teams and subject matter experts to work jointly and provide mutual aid and learning where appropriate • A robust mechanism for risk based decision making and coordination maximising our resources and expertise Has the trust activated major incident procedures including 24/7 gold, silver and bronze delivery and assurance?
What is the governance for the development of the trust's COVID-19 response plan and has the trust's plan been aligned to the local system plan?	Do work-streams have executive leadership and delivery oversight that operate alongside the incident command structures? Have lead clinicians been involved in all stages of the development of the trust's plan? Has the plan been considered and approved by the trust's management executive? Are the trust's plans aligned with the local health and care system? Has a programme of daily activities to manage the incident response been devised?
Have service escalation plans been developed appropriately and have they been assured?	Have senior clinicians led the development of plans for their own services? Are these based on predictive demand modelling? Are they align with those of trusts in the local system? Three types of clinical plans should have been developed: surge plans, service resilience plans and clinical protocols.
Has a comprehensive workforce plan been developed and is it being deployed effectively? Is staff well-being being addressed appropriately including the executive team?	Has a workforce plan been developed for each staff group and is this aligned to service planning across the trust? Have these been developed with staff input? Are senior clinicians and managers should be providing mentoring, advice and support to their colleagues? Have we expanded the occupational health and staff counselling services at the trust? Are the board able to demonstrate that staff feel valued and listened to? What informal and formal support can the executive draw on? Have cover arrangements have been determined for each member of the team to manage two displacements for sickness? Has thought been given to the role of NED to support the executive team? Have trusts across the local system agreed mutual aid if key leaders are off sick and short-term interims are being identified if needed?

Question	What to look out for
Has a communications plan been developed and is it being deployed successfully	Has a communications plan been developed and is it being implemented? Does the plan indentify each stakeholder, key messages and utilise a range of media (such as local television, radio and newspapers, social media and more traditional methods such as emails and team and leadership briefings)? Has particular care been taken to ensure that messages reach staff who do not routinely access NHS Mail? What is the trust's response if staff are leaking stories? Is the plan fully aligned to and complimentary to the local system communications plan?
Have the process for timely and effective reporting to the board been determined?	Does the board receive a progress report at each of its meetings? What steps are in place to ensure that reporting is accurate?