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An Applied Health Research Insider's View of Healthcare Response to COVID-19

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Recently our ARC WM Director was relating to me an interview he had heard on the Today programme (BBC Radio 4) with former Prime Minister Tony Blair. Mr Blair made a range of points around the government response to the COVID-19 outbreak, but amongst these he made the point that in extraordinary circumstances such as this, the traditional silos of government departments were not fit for purpose. He suggested a more fluid arrangement was needed with greater cooperation between departments, or perhaps a specific Minister in charge of the COVID response.

This led me to reflect on changes within the University Hospitals Birmingham NHS Foundation Trust, the organisation to which I have returned in order help with their COVID-19 response, and which has afforded me a privileged insight in to their response. With perhaps seven days lag time to learn from the London experience of the outbreak, the Trust delivered a transformational shift in the model of care. Firstly, whilst still strategically working as a single organisation, the decision was made to move to a site-based model across the four hospitals (Queen Elizabeth Hospital Birmingham, Heartlands Hospital, Good Hope Hospital, and Solihull Hospital). To support this, a team of four Senior Responsible Clinicians were appointed to run each site 24 hours a day, seven days a week, with four senior operational mangers to work alongside them (of which I am one at the Queen Elizabeth Hospital). So one immediate organisational assumption was that specialist leadership was required, but that this leadership could be across clinical specialties, rather than just within them, as had previously been the case.

Secondly, there was an immediate move to a 24/7 consultant-delivered model of care. This means that a resident consultant will take leadership across each of the six floors of the

hospital, whereas previously out-of-hours cover was often provided by more junior grades and/or through non-resident on-call arrangements.

Thirdly, and necessitated by this move to floor-based working, is a more generalised approach to care in order to free up enough clinicians to deliver a resident 24/7 consultant-delivered model. For instance, the clinical consultant lead for a floor might be a colorectal surgeon, who would also be looking after patients from liver surgery, urology and general surgery. Specialist advice is, of course, still available through colleagues, but the consultant lead is responsible for the primary oversight of clinical care for these patients.

Fourth, linked both to the huge requirement for support in the Emergency Department and the Intensive Care Unit as a consequence of the outbreak, some clinicians have been temporarily redeployed to other specialties from those in which they routinely deliver care. This has also necessitated some 'acting down': clearly, however experienced a consultant is in any other area, they are unlikely to be able to operate at the same level in a new area. This breaking of traditional hierarchy has been fascinating to watch, with both great humility being shown by many of those doing so, and considerable zeal for the challenge of working in new areas and with new teams.

This transformational shift in hierarchy and silos of care has been embraced by the overwhelming majority of the clinical teams with the predominant attitude being "we can't go back to they way we used to work". Of course, in some ways the biggest organisational challenges still lie ahead: for instance how do you maintain the best elements of this new model and at the same time begin to re-introduce elements of specialist and standard care, such as surgery, whilst maintaining the flexibility to revert back to a full pandemic response model in the case of a second peak or new outbreak? For applied health researchers there are a wealth of topics to explore around which of the changes endure, and which have the greatest impact in the short, medium and long term. As an ARC we hope to provide leadership on this, in turn rapidly disseminating our findings through partners, such as the West Midlands Academic Health Science Network, to shape future service transformation and pandemic response.