

Developing flexible service provision and workforce roles

Trusts and not-for-profit organisations reprioritised their community health services to staff the discharge to assess model, step up COVID-19 care in the community and maintain essential non-COVID-19 services. This process was guided by the [prioritisation framework](#) issued by NHSEI on 20 March, which provided welcome flexibility to pause or partially stand down some services and increase capacity in discharge teams. Where capacity allowed, providers did not stop services altogether but delivered services differently, sometimes by amending clinical prioritisation or using digital technology.

Community services have been transformed to maintain good infection prevention and control (IPC) protocols, including physical distancing and the use of personal protective equipment (PPE). Community providers cohorted patients, teams and premises into hot (COVID-19) and cold (non-COVID-19) groups to avoid cross contamination.

Community providers also worked collaboratively with primary care (including PCNs) and voluntary sector colleagues to support high-risk individuals advised to shield for 12 weeks. While community service providers' experience of [collaboration with primary care during COVID-19](#) has varied, in many areas they have been working closely together. For example, Croydon Health Services NHS Trust worked with the local GP collaborative to extend medical cover to be available 8am to 8pm seven days a week, which was supported by the multidisciplinary community rapid response service. This enabled management of more complex cases in the community, including end-of-life management.

Community service providers also collaborated ever more closely with acute hospitals during COVID-19. In some areas, geriatric teams that are usually based in hospitals are now providing in-reach to community rapid response services. In other areas, acute hospitals are providing clinical support to care homes as part of multidisciplinary teams. One of the strengths of community service providers is the relationships they hold across the spectrum of local health and care organisations (including primary care; social care; local authorities; voluntary, community and social enterprise (VCSE) providers and so on) and their subsequent ability to coordinate integration at place and neighbourhood level.

Liverpool Heart and Chest Hospital NHS Foundation Trust adapted its community respiratory palliative care service in the first six weeks of the COVID-19 pandemic. Senior healthcare professionals became senior decision-makers in initiating end-of-life care (EOLC) in the community, which was previously a multidisciplinary team decision, as GPs were no longer doing face-to-face contacts. Following some cases where lack of access to EOLC drugs in the community led to poor outcomes and patients not dying in their preferred place of care, the team looked at alternative ways of prescribing and secured future provision. Sharing agreements for electronic care records helped immensely when putting in place plans for patients who needed EOLC. These agreements would normally take months to get signed off but were swiftly approved during the pandemic.