Changes to doctors' working practices emerging from the pandemic

Research findings slide deck | March 2022

Background and methods

The Covid-19 pandemic has brought about large-scale and rapid changes in how healthcare services are delivered and used, and doctors have been required to change and adapt their practice in response. Trajectory were commissioned by the General Medical Council (GMC) to conduct research exploring the changes and adaptations to doctors' working practices that have emerged during the pandemic.

Research questions:

a) What are the main changes to doctors' practice to have emerged from the pandemic?

b) What is the effect of these changes on doctors, patients, healthcare organisations and the wider system?

c) Which changes to doctors' practice should/should not be retained long-term, and why?

d) What are the barriers and enablers for sustaining changes?

Methods:

- A desk review of existing evidence.
- Eight focus groups split between GPs, secondary care clinicians, doctors in training, and those on SAS/LED contracts. Each group contained four to six doctors.
- 19 depth interviews with clinical leads, practice managers and NHS and private hospital managers.

The research was conducted via video interview (Zoom) August to September 2021.

Research headlines

The findings describe some of the major changes that have occurred from the perspective of doctors, clinical leads, and managers. Exploring the future sustainability of these changes was a key aspect of the research, but it's important to note that this remains a rapidly evolving picture.

Major areas of change:

- **Digitally enabled remote working:** *Remote primary care consultations; remote primary care triaging; remote secondary care clinics; remote health monitoring; working from home.*
- **Shifts in roles and responsibilities within the multi-disciplinary team:** *Co-operation between primary and secondary care; integration with community care services; redeployment.*
- **Reconfiguration of patient care pathways:** *Redirecting access to specialist care; use of 'green hospitals'.*
- **Managing the patient care backlog:** *Allocating workforce resources; supporting doctors wellbeing; modified investigation and treatment protocols.*

Priorities for sustaining positive change long-term: Increased staffing; further investment in technology and digital services; training and guidance; changing attitudes; organisation, culture and leadership.

Area of change 1: Digitally enabled remote working

There has been a major shift in the use of technology to enable more remote working, including remote consultation and monitoring. This has supported the healthcare system to function over the pandemic, in particular during lockdowns.

Remote primary care consultations

What has changed?

- A much higher proportion of GP consultations are now being delivered remotely compared to pre-pandemic. The vast majority of remote consultations are currently by telephone as opposed to video. However, software such as accuRx allows patients to securely send pictures and messages.

Impact of the change

- GPs reported that remote consultations gave them more flexibility to tailor the length of consultations. They felt that this helped them manage their caseloads more efficiently, resulting in shorter waiting times for patients.
- GPs also said it had positive effects on their wellbeing. It reduced the time pressure of giving every patient ten-minute time slots. It also allowed them to better structure their day to have breaks and spend time with colleagues.

  "People aren't in neat ten-minute packages, some are going to take longer. So this flexibility is such a plus because [you] can spend time on a patient who needs it, can get the sick notes done quicker, without feeling every ten minutes you're running behind. From a wellbeing perspective, mentally I've been feeling a lot less pressure on that time aspect." (GP)

- However, some GPs reported concerns that remote consultations could increase the risk of missed diagnosis.

  "You miss a lot of non-verbal communication. I worried about missing things."

Remote primary care consultations

- GPs also shared concerns that a remote-first care model may exclude some patients and not be suitable for everyone. This might be because patients have problems using the technology. Or because they feel less comfortable discussing their health concerns over a phone or video call.

> *"Elderly patients who haven't come to see us for their chronic disease have just been left for a year now and are a lot sicker than they were pre-Covid. Those on the severe mental health register – trying to consult with them on the phone is very difficult, these groups have suffered." (GP)*

Sustaining the change

- GPs participating in the research felt that a remote-first model should eventually become the norm. While most acknowledge that there are potential risks, they believe their experiences during the pandemic prove these risks can be managed.

> *"I know as a doctor where I can't complete my diagnosis safely on the telephone and that I need to bring that patient in. We do that all the time." (GP)*

- GPs highlighted the importance of digital software to support remote consultations, such as accuRx that allows patients to securely send pictures and messages.
- GPs also felt that changes to training and education were needed to reflect the shift to a remote-first model.

> *"As well as triaging, use of video consulting requires new skills, such as learning to examine someone when they're not physically in the room. It's something we all need to work on." (GP)*

Remote triaging in primary care

What has changed?

- More remote consultations has coincided with a shift to digitally enabled 'total triage' in primary care. It's possible to triage entirely by telephone. But since the pandemic many practices have used online consultation systems such as eConsult to increase speed and efficiency. Patients can enter their background and symptoms online. A doctor can then assess how quickly they need treatment, and how best to provide it.

Impact of the change

- GPs reported that digital consultation and triage worked particularly well for medical administration like sick notes, prescription requests and medication reviews. It provides a communication trail and many of the doctors we spoke with believe it is more convenient for patients.

> *"Rather than patients phoning or emailing the surgery without a communication trail, things get uploaded onto the patient record, like a prescription request or a medication review, and we can do those easily." (GP)*

- However, the requirement to respond within 48 hours is demanding for doctors. Some partners report doing sixty eConsult cases a day just to reach this deadline.
- Some GPs also felt that providing this model potentially risks devaluing GPs' time and could discourage appropriate self-management of minor ailments.
- Concerns were again raised that marginalised groups of patients may struggle with accessing digital solutions.

Remote triaging in primary care

Sustaining the change

- Doctors described the importance of regulation and guidance in supporting the continued use of digital triage platforms. Where this is already in place, awareness of it may be low.

  "It's an unregulated area, for example [with] eConsult, if there's a failing in the electronic triage and something unsafe has to wait, where does the responsibility for that lie?" (GP)

- GPs also suggest better integration of these platforms with clinical systems to avoid duplication and reduce risk of administrative errors.
- Some GPs raised concerns about the role receptionists are likely to play, particularly when remote triage happens offline. They highlighted that they are not sufficiently trained and most felt that more senior medical staff should be responsible.

Remote secondary care consultations

What has changed?

- There has been widespread use of virtual clinics in secondary care, across many of the specialties represented in the research (e.g. orthopaedics, community paediatrics, psychiatry, oncology). Doctors reported that virtual clinics have been most commonly used for follow-up appointments such as providing test results.
- Digital platforms such as 'Attend Anywhere' have supported provision and access to remote clinics.

Impact of the change

- Doctors participating in the research reported that that remote clinics free up resources and reduce the disruptive impact of non-attendance as doctors can simply move onto the next call.
- They also highlighted that they minimise travel and expense for patients.
- However, doctors reported telephone practice can be isolating and raised concerns that it offers fewer training opportunities and less supervision.
- The biggest challenge in secondary care was felt to be assessing patients' suitability for remote consultations. As well as the clinical circumstances, social factors, such as language barriers and safeguarding have to be considered.

> *"The less unnecessary time the patient spends at the hospital the better. The challenge is: where do you draw the line between necessary and unnecessary – it's very specific to your area." (Consultant)*

Remote secondary care consultations

Sustaining the change

- Doctors across several specialities agreed that remote consultations would continue to be very useful for many follow-up appointments, but most felt that initial consultations should remain face-to-face.
- Doctors raised the need for guidance that provides more clarity on when, and how, to conduct remote consultations. There was concern that without this assurance, a fear of complaints could reverse. innovation.

> *"We'll slip back to how we used to practice five years ago because it's easier [to defend but] with the drawbacks of inconvenience and inefficiency… because it's less hassle." (Consultant)*

- The importance of providing patient choice was emphasised by many, however, clinical leads highlighted the need to also take a standardised approach, to increase efficiency and maintain consistency.

> *"When practice varies among clinicians in the same department or across trusts, that is a recipe for complaints – because patients will say they've not been offered the same service." (Secondary Care Clinical Lead)*

Remote health monitoring

What has changed?

- The pandemic has accelerated adoption and improved attitudes towards technology for remote monitoring of health data (such as for blood pressure, oxygen saturation, electrocardiograms, blood glucose and BMI).

Impact of the change

- Doctors reported that remote monitoring can increase the quality of data available to them, resulting in more productive and efficient consultations.
- Many of the doctors felt that self-monitoring technology has empowered patients to take more ownership of their condition and enables them to self-manage.

> *"Previously having a blood pressure (BP) machine at home was the exception. Now more than half the people I speak to do, so they can take readings for me without having to come in and it then really informs the consultation. Even if it's a remote consultation, it provides me with really useful information which might mean they don't need to come in. That's empowering the patient to self-manage." (GP)*

Remote health monitoring

- However, doctors also warned that self-management options are not right for all patients

> *"I was speaking to a patient today who had anxiety and now she's measuring her blood pressure at home. She has panic attacks and will measure her BP during an attack which makes her panic more, and she's now fixated on measuring her blood pressure even more because she's worried about it. It's worsened her anxiety." (GP)*

Sustaining the change

- Participating GPs and practice managers recognised the important role of remote health monitoring in future practice, and many felt that this has been accelerated by the pandemic. However concerns were raised about significant barriers, such as cost, that prevent remote monitoring being more widely accessible, particularly for marginalised groups in deprived areas.

Working from home

What has changed?

- Many doctors participating in the research now do some non-clinical and administration work from home, particularly clinical leads and managers.
- Some doctors, especially GPs and consultants working in non-urgent care, have also routinely conducted clinics, and even ward rounds, from home.

Impact of the change

- Homeworking doctors in the research report appreciating the autonomy this offers, and several suggested that this enables them to get through more work with less pressure. It has also allowed those shielding or having to isolate to carry on with some work, helping to maintain service capacity during the pandemic.
- However, it was identified that working from home can mean more requests for work and meetings outside normal hours.
- Interviewees also highlight in-person contact as important for protecting wellbeing and team morale – especially the opportunity to debrief with colleagues.

> *"At the beginning you weren't even allowed to have lunch with your colleagues, it was just soul destroying." (Consultant)*

Working from home

- Plus, working from home means doctors aren't as close to their multi-disciplinary teams. It can undermine communication between doctors and management.

> *"Because consultants aren't around, therapists can't grab them as easily to ask questions to, or you're not able to chase them for training compliance or such like." (Private Hospital Manager)*

Sustaining the change

- Working practices are continuing to rapidly evolve. There was an appetite among many doctors participating in this research to retain some homeworking, particularly administrative tasks.

> *"Who knows if they're going to pull that rug at some point? But it will be a travesty if they do. It is definitely one of the silver linings." (Secondary Care Clinical Lead)*

- However, doctors felt that improvements in the technology are needed to enable of expansion of homeworking capabilities and ensure that working from home can continue efficiently and safely.

> *"One consultant was shielding so was only able to attend virtually so sometimes couldn't even hear the full history or pathology and was having to make decisions with really poor technology." (Doctor in training)*

Area of change 2: Shifts in roles and responsibilities within the multi-disciplinary team

Alongside extensive redeployment, the pandemic has driven many changes in the ways that doctors work with their colleagues, both in their own teams, and across the healthcare system.

Co-operation between primary and secondary care

What has changed?

- During the pandemic there has felt to have been greater overlap between primary and secondary care. For example, difficulties getting face-to-face access to GPs driving more primary care into hospitals, or delays in investigations or treatment resulting in the ongoing management of care by GPs.

> *"Primary care around the country is being hammered, and it's difficult for people to get to the GPs because they've got such a backlog. So there is probably more shared care with GPs of pregnant patients, and GPs are monitoring less." (Consultant)*

> *"We had to take over the management for example of rheumatoid patients with flare-ups and [it] wasn't uncommon for us to be giving steroid injections – we took on a lot of [the secondary care] workload." (GP)*

Impact of the change

- In some cases this overlap of responsibilities has led to tension between primary and secondary care settings with some doctors getting frustrated at what they see as having to taking on additional work.
- On the other hand, many doctors also report that working more closely has helped to forge better relationships and collaboration across the system

Co-operation between primary and secondary care

Sustaining the change

- Clinical leads highlighted the role of advice and guidance pathways, teaching sessions, and networking opportunities for maintaining better links between primary and secondary care.

> *"We have a really excellent referral help system where GPs can go online and ask questions to specialists" (Specialist)*
>
> *"Virtual training has been good but unfortunately social and networking opportunities can't occur. You can't create professional networks, those little bridges" (GP)*

Integration with community care services

What has changed?

- Some of the GPs participating in the research described having to rely more on community care services during the pandemic e.g. district nurses, community matrons, or redeployed paramedics taking blood tests or providing certain treatments.

Impact of the change

- Community care services have helped relieve some GP's workload during the pandemic, particularly among those who may have been under-utilising community care services in the past.

> *"Previously we didn't rely on the community services, like the community matron, district nurses, we tried to deal with everything by ourselves. During the past year we had to use the community services, and that's been a learning [curve] for us … We don't need to go to see every single patient, there are other services that can go and see these people." (GP)*

- Doctors also highlighted that better integration with community care services improves outcomes for patients as they can access more tailored and appropriate support. For example, social care prescribers look at the social determinants of health – like housing, finances and food poverty.

> *"It's a real benefit to the patient and the system, instead of presenting six times over two months feeling they've been fobbed off without help." (GP)*

Integration with community care services

- However there have been gaps in availability.

> *"In my small practice we had a close relationship with the community services. But with the pandemic the district nurses have been overloaded so have struggled to see patients to do bloods, dressings, so we've had to organise to do that ourselves." (GP)*

Sustaining the change

- Many of those participating in the research felt that GPs are better embedded in community care services now, and that it is vital that these links are maintained after the pandemic. Newer types of team members in primary care are likely to grow in number in the future. These include care coordinators, who ensure patients gain access to the support they need.
- However, clinical leads and managers participating in the research felt there was a lack of clarity around the responsibilities of GPs who rely on healthcare professionals who aren't clinicians. They questioned the current individual focus of regulation, training, guidance and investigation; highlighting the gaps in regulation covering teams.

> *"There are duties of a doctor but there are also duties of a general practice system – any given day there's five doctors answering phones and seeing patients, but you also have nurses, pharmacists, first contact practitioners, social prescriber link workers, care coordinators as well as our admin team stepping up and doing other health administrative tasks. Care is delivered by that group." (Primary care clinical lead)*

Redeployment

What has changed?

- During the pandemic many doctors have been redeployed, both within their own speciality/area of practice and outside of it, in order to cope with the demand.
- Trainees have been the most likely group of doctors to be redeployed during the course of the pandemic. Redeployment of more senior doctors, while used in the first wave, has become less common.

Impact of the change

- Doctors acknowledge that redeployment, and the workforce flexibility it offers, has helped to get the NHS through the pandemic, particularly in the first wave. They also recognised the sense of camaraderie and "pulling together" that came with it.
- Some redeployed doctors in training actually had a more positive experience in terms of senior support, especially in teaching hospitals.

> *"From my point of view as a junior on a London Covid ward I found senior support was better. More consultants were around. I felt really well supported, it was really helpful" (Doctor in Training)*

- However, while redeployed trainees appreciated greater leniency and flexibility in training during the pandemic, many still feel that their training has been negatively affected due to lost opportunities. Foundation year doctors in particular feel more uncertain about making future career choices without adequate exposure to the specialisms they're most interested in. While some registrars feel that they are not confident to progress in their chosen speciality.

Redeployment

"If you're not getting the clinical exposure you're supposed to get [then] there's no use being signed off for it because at the end of the day when you get your CCT and become a consultant you've not had [the] exposure you need." (Doctor in training)

- Generally doctors felt that the transferable skills they have gained from redeployment have been fairly limited, and some currently redeployed doctors are concerned that the homogeneity of their current workload will impact their confidence and skills when they return to their normal roles.

"I haven't been able to go back to colorectal surgery which is making me nervous. I'm raising this again and again but there seems to be no answers." (SAS/LED)

Sustaining the change

- Doctors participating in the research recognised that some level of ongoing redeployment could have benefits, particularly in tackling the backlog of patient care.

"Pathology doesn't need F1s for service delivery. Respiratory will have 20% extra cases. A short-term solution that isn't ideal but necessary is redeployment." (SAS/LED)

- However, many also emphasised that redeployed doctors need better support. Particular areas to prioritise noted in the focus groups included: minimising how often doctors are swapped between wards or teams, more comprehensive inductions, standardising administration across hospitals, and protecting study leave.

"Every day I was on a different ward, every department runs rotations differently – it's chaotic." (Doctor in training)

Area of change 3: Reconfiguration of patient care pathways

Teams across the healthcare system pulling together to support each other has paved the way for service and pathway innovations. This has included implementing more direct access to specialist care, and greater separation of acute and elective care settings.

Redirecting access to specialist care

What has changed?

- The urgent need to control the spread of infection and ease pressure on services during the early stages of the pandemic prompted a range of processes to manage attendance at GPs and A&E. Many hospitals put in place more direct access to specialist care, for example changes in pathways to mental health departments and musculoskeletal services.

> *"Previously a mental health patient would have come in and waited in the emergency department. The service has now been moved to a bigger area so when the patient comes in and is assessed they're sent directly over. We no longer spend five or six hours with this type of patient in the emergency department." (NHS Hospital Manager)*

Impact of the change

- Doctors reported that reconfiguration of patient pathways in this way helped to deal with patient demand more efficiently and relieve considerable pressure on A&E staff during the pandemic.
- Managers participating in the research also felt that these changes could mean faster access to specialists and fewer hospital visits for patients.

> *"Forty per cent of patients were discharged from hospital in their first visit and didn't need to come back. The patient only has to come into hospital once rather than two or three times." (NHS Hospital Manager)*

Redirecting access to specialist care

Sustaining the change

- Many of the clinical leads and managers felt that it would be beneficial to keep these changes to patient care pathways longer term.

  "Push more expertise towards the front door so patients are only admitted when they need to be; to provide urgent care pathways that function and work but which avoid hospital admission; and to stop patients admitted on urgent care pathways waiting a week for a test because access to the correct expertise isn't available." (Secondary Care Clinical Lead)

- However, some warned that this would only be possible with system wide changes, particularly where staff aren't working the same hours.

  "There is no use having…sites without the expertise to deliver that or the resources or working patterns, you need a systems approach that works." (Secondary care clinical lead)

Use of 'green hospitals'

What has changed?

- During the pandemic some trusts/boards set up 'Green' hospitals. These were designated 'Covid-free' and only dealt with non-Covid routine work. The designation of separate sites for more routine care is not a new phenomenon, but during the pandemic it was implemented more widely.

Impact of the change

- 'Green' hospitals have been used to successfully help keep general surgery and routine lists under control. But there has been problems with implementation, especially in dealing with the definition of 'Green' status and potentially changing the status of patients.

> *"One day you might have Covid another day you might not. Government guidelines aren't clear, we jump from one extreme to the other." (Secondary Care Clinical Lead)*

Sustaining the change

- Retaining greater capability to separate acute and elective care was seen by clinical leads and management as potentially important for managing future winter crises.

Area of change 4: Managing the patient care backlog

The UK healthcare system is faced with tackling the backlog in non-covid patient care, putting an already stretched workforce under even more pressure. Different approaches to allocating resource and new initiatives to support doctors have emerged during the pandemic.

Allocating workforce resources

What has changed?

- Doctors reported that managing fluctuations in demand has been a particular challenge for hospitals during the pandemic.
- Action taken by providers to cope with this fluctuating demand have included redeploying staff, employing more locums, 'doubling up' rotas, and returning to more 'firm-style' teams.

Impact of the change

- Some doctors reported that capacity problems have led to more doctors working beyond their usual scope or specialism.
- Ultimately doctors did feel that in some cases reduced capacity had affected the care received by patients during the pandemic, particularly in settings such as intensive care.

> *"We pretended we were delivering the same quality of intensive care medicine. We weren't. There's no way you can… when you're spreading one critical care nurse to four patients instead of one to one and likewise the dilution of doctors and so forth." (Consultant)*

- 'Doubling up' rotas, especially at night, and a return to 'firm-style teams' was felt by some to have resulted in better supervision for trainees and care for patients.

Allocating workforce resources

- However, these solutions can be costly, and in some circumstances were reported to have led to overstaffing and wasted resource during the pandemic.

> *"Suddenly we have another Covid ward that we don't have staff to cover. Then it suddenly disappears again but by that point we've got staff that we're then paying but we don't need anymore. And then it goes back again" (SAS/LED)*

Sustaining the change

- There was support for retaining some of the rota innovations implemented during the pandemic, such as 'firm-style teams.

> *"Our rota is much more trainee-centred now because we had to write a rota that could cope with suddenly six people (two wards' worth of cover) isolating, so we restructured everything into teams a bit more like the old style of being in a firm so the consultant and junior doctor would all be the one team and there was a bit of cross cover as necessary but actually that's been quite successful and that's definitely something we're keeping on as a department." (SAS/LED)*

- However, while these changes may reduce pressure on doctors while they work, if the number of posts don't increase it means working more shifts, contributing to burn-out and workforce attrition long-term.

Supporting doctors wellbeing

What has changed?

- The challenges and complexities of living and working on the frontline during a pandemic has put many doctors under immense stress. They will continue to work under increased pressure as the healthcare system tackles the patient care backlog.
- People across the healthcare system have come together to support each other during the pandemic. For example, many report the importance of debrief sessions for cases that may be particularly traumatic.
- New initiatives to support doctors' wellbeing have also been introduced during the pandemic, such as better support services, wellbeing spaces and even massages.

> *"Our directorate has built a wellbeing room, a comfortable place to reflect, have a cup of tea, [and] sit in peace and quiet. We've got wellbeing champions/officers from various specialisms trained as support workers overseeing wellbeing." (Secondary care lead)*

Impact of the change

- Many of the participating doctors expressed concerns that increased workload pressure is affecting the care provided to patients. When doctors felt patient care suffered, it negatively impacted their own morale.

> *"It was not the same quality of service – it was heart-breaking." (Consultant)*

Supporting doctors wellbeing

- While doctors have appreciated some of these wellbeing initiatives, many report not having time to actually use them.

Sustaining the change

- Although doctors welcome a greater recognition of wellbeing issues, many highlighted that improving staffing levels and reducing workload are the actions most likely to make a positive difference.
- The importance of having senior leaders and managers who are visible and readily available was also highlighted.

> *"The pandemic has taught me this is so important. Wellbeing posters and screen savers aren't the same as putting your hand on someone's shoulder and asking if they're alright. It's equally important as having counselling facilities" (NHS Hospital Manager)*

Modified investigation and treatment protocols

What has changed?

- Some doctors participating in the research described requirements to prioritise services more carefully during the pandemic. For example, reducing eligibility or mandating alternative tests and procedures.
- The pandemic has also led to the development of new alternative clinical diagnosis procedures, that could be implemented despite pandemic restrictions.
- Practices such as of pooling waiting lists, across departments or wider networks, have also become more common place.

Impact of the change

- Doctors participating in the research were able to provide examples of where pandemic has driven positive innovation, with the development of more efficient alternative procedures.

> *"We developed a long waiting list because our autism diagnostic tool is an hour assessment and can't be done remotely or wearing a mask. Instead, we pragmatically launched a different tool called the British Observation of Symptoms of Autism, a bridge tool that can be delivered in half an hour, and has been ratified, delivered face to face alongside good quality telephone information gathering." (Secondary care clinical lead)*

Modified investigation and treatment protocols

- Concerns were raised about management pressure to ration investigations and treatment.

> *"I feel doctors are being put on the spot and when things go wrong it will be individual doctors' faults – their judgment that was wrong when it was actually an institutional bias to push back on account of reduced capacity*

Sustaining the change

- Many of the doctors participating in the research felt that where evidence suggests a more efficient but just as effective alternative is available, new protocols should remain in place.

> *"A lot of colonoscopies aren't really necessary so you end up delaying the ones that are. We took a more proactive approach to triaging, requesting alternative tests such as stool markers and if those were negative then go back to the GP or patient and say you don't need a colonoscopy, because we know you don't have cancer. These things have been around for a while, but we've been stuck in this way of if a GP refers to us for a colonoscopy we give it but [that's changed] because we had to prioritise because of the backlog. It worked brilliantly and I'm sure it will continue." (Consultant)*

- However, some doctors warned against non-clinical management becoming too involved in these decisions.

Priorities for sustaining positive change long-term

Factors identified as most important for enabling positive change to be sustained include robust investment in staff and technology, expanded and flexible guidance, and shifts in culture.

Priorities for sustaining positive change long-term

1. **Increased staffing:** Increasing capacity across the workforce is felt to be necessary for many of the changes to working practises described in the research to be sustained longer-term. This will be particularly important to support doctors' to manage under increased pressure as the NHS tackles the backlog of patient care.
2. **Further investment in technology and digital services:** Technology has enabled more efficient working practices and a better, safer experience for patients during the pandemic. However, participants emphasised the need for further investment, better integration of platforms and systems, and strategies to make sure digital solutions are accessible for more patients.
3. **Training and guidance:** Participants stressed the need for guidance and supported learning opportunities that keep pace with changes, and provide doctors with more confidence and assurance when applying new ways of working. The importance of this was particularly highlighted in relation to remote care where doctors called for more clarity on when, and how, to provide remote consultations.
4. **Changing attitudes:** Successful implementation of some of these changes will require working with patients and the public to educate and raise awareness about new models of healthcare. For example, using digital services first, where appropriate.
5. **Organisation culture and leadership:** Innovation beyond the pandemic requires cultures of transparency, empowerment, learning and collaboration. This is characterised by effective leadership and communication, minimising bureaucracy, increasing staff autonomy, and making sure time and resource is available.