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Published version

FOWLER-DAVIS, Sally, CHOLERTON, Rachel, PHILBIN, Mandy, CLARK, Kathy and HUNT, Gill (2021). Impact of the Enhanced Universal Support Offer to Care Homes during COVID-19 in the UK: evaluation using appreciative inquiry. Health and Social Care in the Community.

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ORIGINAL ARTICLE

Impact of the Enhanced Universal Support Offer to Care Homes during COVID-19 in the UK: Evaluation using appreciative inquiry

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Funding information

Better Care Fund via NHS Sheffield CCG.

Abstract

There are over 2,300 care homes in the North East and Yorkshire Region, with rising rates of COVID-19 infection in April 2020. The Enhanced Universal Support Offer (EUSO) planned to improve support to care homes, working collaboratively with local integrated community services. Implementation was organised at 'place', through clinical commissioning and it was focused on leadership, prevention, additional clinical support, and workforce planning. The aim of the evaluation research was to understand the impact of the EUSO. The evaluation was co-produced by a group of senior leaders with additional academic involvement. An appreciative inquiry approach informed the interviews and focus groups with representative stakeholders. A thematic analysis using NVivo enabled a validation process and the data were charted into a systems framework. Data analysis resulted in five high level themes: Communication, Working Relationships, Systemic Perceptions, COVID-19 Implementation, and Organisational Support. Best practices were associated with joint working between health, local authority and care homes including medication optimisation and technology use. Care homes valued access to a named General Practitioner and community nursing working as a part of a wider multidisciplinary team. Conversely an overly reactive response to care homes combined with 'command and control' limited the benefits that were achieved. The EUSO was delivered at pace and resulted in an increased appreciation of the policy and principles of care home residents and workforce. The evaluation reflected a need to appreciate the care homes' knowledge and experience of resident wellbeing, and more fully involve them in the design of the support.

KEYWORDS

appreciative inquiry, care homes, COVID-19, evaluation, integrated services

Abbreviations: CCG, Clinical Commissioning Group; EUSO, enhanced universal support offer; ICS, integrated care system; NE&Y, North East and Yorkshire.

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1 | INTRODUCTION

In February 2020, English care homes rapidly adapted their practices in response to the COVID-19 pandemic. In March 2020, NHS England & Improvement (NHSE&I) published the refreshed 'Framework for Enhanced Health in Care Homes' (Didehva et al., 2020), requiring the NHSE&I in seven regional teams to implement specialised services at a local level across England. A multi-agency collaborative approach was regionally organised, namely, the 'Enhanced Universal Support Offer to Care Homes' (EUSO) to reconfigured community services (Marshall et al., 2020). Using a networked approach to delivery, backed by appropriate information sharing arrangements (Didehva et al., 2020; NHS, 2020a) the emergency response included escalation processes associated with personal protective equipment (PPE) and COVID-19 testing along with an IT infrastructure to support virtual consultations (BMJ, 2020b).

With over 2,300 CQC registered care homes in the North East and Yorkshire Region (NE&Y) and with rising infection rates, 12% additional mortality was recorded in April 2020. In response, partner organisations across health and social care combined efforts and expertise around a set of 'universal principles' that included leadership, prevention, additional clinical support and workforce. Implementation was planned to be delivered at pace by four integrated care systems (ICS) with self-assessment against core metrics in May until July 2020. A configuration of organisations included primary care, public health and local authorities to be accountable and responsible for the quality, financial and operational performance, and assurance of the NHS.

The EUSO included key improvements that included ensuring that every care home had a named clinical lead (e.g., a General Practitioner [GP]), a daily supportive call (from a partner organisation), and access to infection prevention and control (IPC) advice and training. In addition, a daily or virtual visit was offered by a community nurse, and support to develop outbreak plans. All residents were required to have personalised care plans and to raise concerns via an existing capacity tracker online system. A weekly multidisciplinary team (MDT) meeting with GPs, community nurses and allied health professionals was undertaken with each home, to support vulnerable residents and access specialist community services (i.e., pharmacy support for medication supply and review). As residents being discharged from hospital to care homes were a serious infection risk, care home staff were offered testing, psychological support and 24-hr guidance and end of life guidance, using remote monitoring and online educational resources.

1.1 | Care home context

The impact of the virus on care homes was a critical factor in designing system changes and policy implementation measures, to ensure that early failures were addressed and that a EUSO was made available to care homes.

The care home sector is predominately made up of independent commercial organisations with local authorities and clinical

What is known about the topic

- The COVID-19 pandemic had a devastating effect on care home residents
- Regional planning sought to alleviate harm with community services
- A sustained approach to transformation is needed in workforce, funding models, technology adoption and integrated care

What this paper adds

- An evaluation of impact of the enhanced offer to care homes during the pandemic
- Interagency, cross sector and multidisciplinary relationship and communication led to better outcomes
- Re-confirms the need for consistent effective leadership and delivery of integrated care in association with the care home sector

commissioning groups funding a proportion of care home residents with formal contractual arrangements. The structure of the sector and contractual arrangements institutionally separated from the health system have been cited as a critical factor in response to the pandemic (Daly, 2020). The widespread market dependence on care homes to care for the oldest and most vulnerable adults created a highly complex system of provision (Devi et al., 2020).

By May 17, 2020, the CQC reported 36% of care homes in England had reported an outbreak of COVID-19 (Care Quality Commission, 2020), with mortality concentrated in homes with known outbreaks (Burton et al., 2020). Care homes individually and collectively introduced significant local policies and practices to shield residents and to minimise outbreaks of infection. Systemic and organisational issues included staff turnover, care worker sickness, supply and expense of agency staff, IPC measures, and during the early stages of the pandemic, access to and costs of PPE (BMJ, 2020a).

By the end of June 2020, there had been 21,775 deaths recorded nationally, within care homes from COVID-19 with care home residents accounted for at least 40% of all COVID-19 related deaths in the UK (Bell et al., 2020); the highest mortality rates in Europe (Devi et al., 2020). In addition, a survey evaluation of 9,000 care homes in England identified potential risk factors such as the prevalence of infection in staff and the use of agency staff (ONS, 2020). Critical review of the measures has suggested that widespread testing, and more embedded health and care practices would have resulted in fewer deaths and better outcomes for residents (Devi et al., 2020).

The pandemic presented unprecedented challenges that required a well-coordinated response across central and local government, health services, and non-government sectors (Comas-Herrera et al., 2020). More integrated working between care homes and primary health services was deemed to have the

potential to improve quality of care (Gage et al., 2012). As a result of the current context of COVID-19 and literature highlighting the importance of integrated working in improving quality of care, the aim was to understand the impact of the universal enhanced support offer to care homes using co-production methods, appreciative inquiry (AI) and analysis.

2 | METHOD

In July 2020, this qualitative evaluation was commissioned to begin to understand the impact of the interventions and the success of the implementation process. The principles of AI were used to inform the design of the evaluation. AI is considered to be a strength-based approach that focuses on positive dialogue and change (Trajkovski et al., 2013). It has been used in previous research to help transform practice in healthcare and social care settings (Scerri et al., 2019; Watkins et al., 2016) and has been effective in promoting a collaborative approach to change within the health & care systems (Lavender & Chapple, 2004; Trajkovski et al., 2013).

The evaluation took place between July and October 2020, in the context of a continuing pandemic. The evaluation design sought to engage participants and stakeholders selected for their involvement in delivering the EUSO programme, working in NE&Y region of England.

The co-design of the evaluation was undertaken by a steering group of representatives chaired by the Senior Clinical Lead NHSE/I in NE&Y region and included academic involvement. The group included Public Health, an Associate of ADASS, representatives of the Better Care Fund and Skills for Care and Chief Nurses and Directors of Nursing of the CCGs. They committed to participate in an experience-based investigation reflecting the constructionist approach of AI (Bushe & Kassam, 2016), using their shared knowledge of health and care management and a commitment to guiding principles, end goals and timescales (Greenhalgh et al., 2016). The steering group developed the approach and designed data collection methods, engaged academic partners to undertake analysis and participated in several workshops to synthesise data. For example, the interview topic guide was formulated based on the 4-D cycle; Discover, Dream, Design, Destiny (Ludema & Fry, 2012).

Qualitative interviews and focus groups took place between August and September 2020, following the first surge of the COVID-19 pandemic and following the initial delivery of the EUSO. Ethical approval was provided by Sheffield Hallam University (Approval ID: ER26371908, August 2020) and carried out in accordance with the relevant guidelines and regulations to complete the study. As a service evaluation, no further Health Regulation Authority (HRA) approval was necessary. The study was sponsored by NHSE&I and funded by the Better Care Fund NE&Y. The paper is reported following the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007).

2.1 | Recruitment

Purposive sampling was used to recruit participants to take part in interviews and focus groups. Those working in or with care homes for older people and learning disabilities in the region specified were recruited. Participants were community practitioners; nurses, pharmacists, care home managers and staff representatives and GPs. Managers of services were also included from all participating organisations. They were contacted by the project lead and provided with a participant information sheet before being invited to interview. Emails were sent to confirm interview times (one-to-one) or in focus groups, via video call. Informed consent was obtained from all participants, based on their verbal consent to the interviewer. Interviewers asked the participant to respond clearly with 'yes' or 'no' and recordings were kept for assurance purposes. Video calls were chosen due to coronavirus social distancing guidelines and were arranged via NHSE&I administration, enabling specific targeting of groups and individuals across the region. Participant lists and data were all retained in the NHS. A group of Public Health Support Officers and Graduate Management Trainees were involved in the project and trained to use AI methods and a data collection tool that was co-designed by the steering group.

2.2 | Data collection

Six interviewers undertook data collection. A combination of interviews and focus groups were planned, to reveal different findings relating to the EUSO offer and contribute to a complete understanding of the support given (Lambert & Loiselle, 2008). Interviews and focus groups were planned to find out about the individual managers' and staff attitudes, beliefs and feelings arising from the programme, and enabled a multiplicity of views and understandings from groups.

A facilitated interview or 'topic' guide was used to direct 40-min interviews and answer questions pertaining to the evaluation of the EUSO, where they had been directly tasked with care home support during the pandemic. The topic guide included; a description of the benefits of the support offer, and prompts included, what factors helped the effectiveness of the support offer, and whether there was any feedback from residents and families (see Appendix 1).

Field notes were taken by the interviewers during and directly after the interviews and focus groups and recordings were reviewed to support accuracy. Participants were sent a debrief sheet with contact details for the purpose of post-interview queries or concerns. Field notes were chosen to be able to highlight important and salient discussions at the time of interview (Tessier, 2012).

2.3 | Data analysis

Data analysis followed a hybrid approach, as developed by Fereday and Muir-Cochrane (2006), enabling inductive and deductive thematic analysis. After interviews and focus group data were collated,

an initial meeting with a sub-group of the steering group, one of the interviewers (a public health graduate) and stakeholder discussed coding and identified salient themes from a sample of the interview and focus group field notes. Agreement was reached around initial themes, focusing on cultural aspects of the care sector, relationships, infrastructure, communication, and care sector procedures. Further analysis included testing the reliability of the code, with members of the research team coding documents with the codes and themes identified.

One member of the research team continued to summarise data and worked in an iterative manner, using inductive and deductive coding. The research team developed five overarching higher order themes with single comments from interviews and focus groups. NVivo 11 (QSR International Ltd.) was used to organise codes and lower order themes into the correct higher order themes.

2.4 | Data synthesis

Data analysis was followed by an online workshop that involved the steering group of the EUSO, for the purpose of building a shared understanding of the data (Birt et al., 2016). The group prioritised higher and lower order themes and organise data into 'organisational levels' (microsystems, mesosystems, and macrosystems). A 'Systems Transformation Framework' (Staines et al., 2015) appeared to support the presentation of data; enabling the recognition of impact from the integrated approach to the programme and reflecting the focus on 'bottom up' as well as top down improvement considerations (Côté et al., 2020; Williams et al., 2009). The macrosystem applied to any lower order theme relating to National Policy and Systems, the mesosystem applied to lower order themes relating to the ICS areas, and microsystem relating to any lower order theme focusing on frontline teams and services (e.g. care homes themselves). Recommendations were formulated from the framework for presentation to further NHS personnel.

3 | RESULTS

3.1 | Participants

Fourteen one-to-one interviews and eight focus groups were conducted. Interviewees represented providers and planners associated with care homes across four ICSs in the regions. Participants were classified into four groups: registered managers (e.g., care home managers), community practitioners (e.g., community nurses, CCG pharmacists), primary care practitioners (e.g., GPs), and senior managers (e.g., service directors, CCG chief nurses). Focus groups were conducted with similar professionals in each group (e.g., community nurses taking part in one focus group) and contained between two to ten participants. Specific interview quotes and focus groups are anonymised to protect participant identity. See Table 1 for further information.

TABLE 1 Overview of participants

Type of participant	No. of focus groups	No. of interviews	Total participants
Registered managers	2	2	9
Senior managers	3	4	19
Community practitioners	3	4	21
Primary care practitioners	0	4	4
			53

3.2 | Themes

Five themes were generated from the data in relation to the EUSO in care homes. These are Organisational Support, Working Relationships, COVID Implementation, Systemic Perceptions, and Communication.

3.3 | Organisational support

There were a range of benefits in care homes, including positive support in training care home staff and utilising technology for remote consultations. One example from a participant was the hope that the systems continues 'to use technology to reduce barriers between care homes and GPs. We've come along so much in COVID, not to lose that.' (Community practitioner, focus group).

Facilitators under this higher order theme include *Integrated Leadership, Consistent Training, Technology Adoption and Access to Clinical Practitioners*. Participants commented that the *clear delegation of leadership across organisations* was a significant facilitator for an effective offer (registered managers, focus group), which enabled rapid decision making and a sense of control in care homes, for example, clear local authority leadership facilitated good reporting measures, messaging, and guidance. Regionally devolved leadership enhanced the responsibility of ICS leads and one participant noticed the direct effects of this transfer of leadership,

Because the enhanced programme firmly put the responsibility if you like, or the leadership in the Directors of Nursing... that gave me the opportunity or very much allowed me to work with them [care homes]

(P2, senior managers, focus group).

Consistent training was highlighted as being a facilitator in interviews and focus groups, with one interviewee (registered manager) highlighting that the training regarding PPE had been useful to enable prevention planning. There were "carers [who] had a willingness to learn new skills" (P1, registered managers, focus group), that had previously been underutilised. *Technology adoption* was commonly discussed in focus groups and interviews, and facilitators in this area

included the *successful integration of IT clinical systems and tablets*, to the *supply of video calling software for MDTs*. Many service providers and ICS staff highlighted the usefulness of *introducing tablets into care homes*, preventing unnecessary visits (community practitioners, focus group) and contacting GPs and families of service users (registered managers, focus group).

Conversely, sub-themes in learnings included a *Lack of Clinical Support*, *Technology Gaps*, *Training Shortfalls*, and *Leadership Gaps*. A *lack of technology integration* was reported with frustration about the lack of interoperability and poor internet connections. Different IT systems were used across service providers, stating 'GPs aren't on the same IT system so we can see the same resident but we don't know what has been done' (P2, community practitioners, focus group). There was a reported *need to identify strong and clear leadership at all levels* with many expressing the need for greater coordination of support in relation to knowledge and dissemination of guidance "One of the challenging areas was around public health leadership... they need to be able to respond quickly with guidance" (P1, senior managers, focus group). In some cases, no clinical support was offered and the impact of the EUSO described as being 'next to none' (registered manager, interview).

3.4 | Working relationships

The EUSO was designed to build on the existing relationships between the care home sector and the microsystems delivering direct care and the mesosystem offer of coordination. Sub-themes included *Thriving Connections*, *Staff Wellbeing* and *Families*. Service providers welcomed the EUSO as an opportunity to build relationships across the community; with nurse teams, carers and residents (Primary Care Practitioner, interview). Some registered managers felt they had *solidified relationships that were already there before the pandemic* (senior manager, interview). Community nurses and pharmacists experienced *more engagement from MDTs* and felt that there was *collaborative working between care homes and stakeholders*. One care home chief executive cited an increase in sharing of information at the mesolevel, between public health and health commissioning. Another senior manager said 'as a statutory organisation we are working much closer, and Public Health which we haven't mentioned yet have been there, so that is a definite positive' (P2, senior manager, focus group).

The analysis also revealed *Resistance to Full Collaboration* and some continuing frustrations about access to homes; 'they' [care homes] were "tetchy about people coming in and out" (P2, Community Practitioner, focus group). *Variation in Commitment to Shared Outcomes* reflected the wide and continued variation in services resulting from working relationships. There was frustration expressed about *strained relationships*, and community practitioners assumed "that everyone was a COVID [case]" (P1, registered managers, focus group). Some care providers reported a lack of involvement from medical professionals, and there were varying statements from care providers, some highlighting a *lack*

of involvement from medical professionals, reflecting varied commitment of community teams.

3.5 | COVID implementation

Implementation was deemed impactful, but depended on the availability of preventative measures. This theme included sub-themes relating to *Early Implementation*, *Enhanced Operational Practice in Care Homes*, *a Nominated GP or Nurse*, *Policy Supporting Practice*, and *Effective Processes for Care Planning*. *Early Implementation* was discussed by most interviewees and focus groups, and *pre-implemented support before the lockdown* was considered a key benefit. Some care home providers felt that their care home had been proactive and had locked down before the guidance was confirmed (registered managers, focus group). Some NHS CCGs had their own infection control teams (senior managers, focus group), and one interview stated that one local care home ignored the support offer as they were already receiving services (primary care practitioner, interview). One practitioner stated that due to collaborative planning 'this has brought us closer together to work in partnership... 10 years forward' (P5, Community Practitioner, focus group). Other important aspects of EUSO implementation included the *Nominated GP or Nurse*, with registered managers and community teams welcoming this as one of the more impactful initiatives. One registered manager called it a "huge success," and a benefit "having someone who understands and to be with you" (P7, registered managers, focus group). Equally, senior managers acknowledged the benefit of having a nominated medical professional, stating that "I think just gives them the support that they're not on their own" (senior manager, interview).

The assets generated were not experienced across all areas. Other sub-themes include; *care home heterogeneity of the response to COVID*, *Command and Control*, *Poorly Operationalised Care Planning*, *Poor Responsiveness to Pandemic*, *Poor Equipment and Resourcing*, and *Poor Care Home Sector Receptivity*. One nurse stated "I think the main thing that would make a difference would be to somehow put some sort of governance, or leadership in place... we almost need to treat it [health and social care] as one unit" (P2 senior managers, focus group). Other sub-themes reflected the view that there was *inflexibility for different types of care home*, with one care home manager stating, 'there is a one size fits all approach' (P2, registered managers, focus group). In relation to the much-reported *lack of suitable discharge procedures*, one service provider highlighted that it 'would have been really useful to have a communication mechanism put in place so that the right people got the right information when that patient was discharged' (Community Practitioner, interview).

The critical issue in discharge planning was the *reduced access to PPE* and a *lack of testing* which were perceived as the main reason for viral transmissions within homes and between hospitals and care homes. One service director stated that the testing for care home staff was not properly implemented and that they were 'supposed to be offering antibody testing for care home staff, domiciliary carers.... but it's not working' (senior manager, interview). Other care home

managers found that they had been supported in other areas, but 'were let down on PPE' and that local councils had to find PPE for them (P4, registered managers, focus group).

3.6 | Systemic perceptions

This theme describes the wider perceptions held about the care home sector and the public view during the pandemic. There was a wide *Recognition of the Care Home Sector* alongside *Changing Perceptions within the Care Sector*. 'People are really valuing us' (P2, registered managers, focus group) was echoed by senior managers stating 'Health colleagues within the CCG are more interested now in what's going on in care homes and there's an urgency in delivering some of the items on the plan' (senior manager, Interview). Of note was a shift in perception, a *recognition that care homes are residential homes to residents*. There was a growing acknowledgement among health and care managers in the value and positioning of 'a home' and an increased recognition of the value of a resident and their place in the care home.

In contrast, some *care homes felt abandoned*, reflecting the view that the care home sector had not been recognised fully for their role in the management of older and vulnerable people. Although one care home manager stated that 'confidence in the sector is rock-bottom', in part due to the negative media representation (P2, registered managers, focus group). *Low care home morale* was also a theme noted in discussions, especially around COVID and end of life procedures. One care home manager stated that 'due to the infection you couldn't do end of life...very difficult to mentally to find positivity within you... we are still recovering... it was very hard to lose loved ones so suddenly.' (P5, registered managers, focus group).

3.7 | Communication

The *Accessibility of all staff (in relation to resident need)*, *Enhanced Engagement*, *Enhanced Formal Communication Processes*, and *Enhanced Collaboration Across Health and the Care Home Sector* all demonstrated the ways that the EUSO supported improved communication. One recurring theme discussed by service providers was the *Constant Contact with Care Homes*, which was praised by nurses and pharmacists. Alongside, the *Direct Contact with a GP or medical professional* was again cited by participants. One Community Practitioner stated that the 'direct contact with the GP makes them [care homes] feel very well supported' (community practitioners, focus group). Equally, the *positive collaboration with MDTs* was considered beneficial due to groups talking regularly with each other, and the *Consistent Approach from CCG and Local Authorities* was seen as positive, with care home managers stating that CCG calls were well attended and information sharing was beneficial to changing practices. One registered manager noted the praise that he had received from a resident's family member,

[Care home name] staff have been amazing during this pandemic. They go above and beyond in the case of their residents. They absolutely love it there. [Care home name] is not like a care home, it is like a family unit, and one I am so pleased that my daughter can be part of

(registered manager, Interview).

Also noted was *Reduced Communication between the CCG, Local Authority and Service Providers*. One service provider noted that 'communication was always an issue that we'd identified as a barrier between CCG, LA and care homes' (Community Practitioner, interview). Another interviewee also stated the lack of communication on certain discharge procedures in their area, noting the following:

If you're sat as the manager of a care home, you probably don't understand why you're being pressured to take a Covid positive patient from hospital, because you don't understand how the situation is potentially going to be, ...

(Community Practitioner, interview)

Other discussions centred around the *Reduced Communication between Service Providers and Families*, and the *Weekly Check-in Difficult to Maintain* for some service providers and care homes. One focus group participant noted that they felt 'there was conflicting information' and 'it was like the blind leading the blind' (P1, registered managers, focus group). The conversations reflected the occurrence of guidance being issued with very short timescales for implementation. For one manager '[The guidance was] released on a Friday which was a nightmare after an 80 hr week. You're knackered, you're nearly at crying point sometimes, and you get faced with this guidance.' (Registered Manager, interview).

3.8 | Data synthesis

At a national and policy level (macrosystem), there was an increased appreciation of the sector and a shift away from negative perceptions, with an increased understanding about the value of investment in new ways of working that focused on care home resident wellbeing. At mesosystem level (ICS and CCG's at regional level), there was an appreciation of joint working between health, local authority and care homes and a renewed commitment to building integrated structures, systems and processes, for improvement of care home resident outcomes. Investment in medication optimisation and technology use was particularly noted, with participants highlighting how methods of connecting with residents were maintained, or even enhanced, during the lockdown. Finally, the third level of impact was the microsystem which reflected local improvement including primary care teams and care home managers' activities that linked to care home delivery. Table 2 (below) identifies operational benefits and assets and weaknesses recognised at each level. The synthesis helps to demonstrate enhanced

TABLE 2 Framework themes linked to micro, meso and macrosystems change

EUSO impacts	EUSO weaknesses
<p>Outcomes in relation to organisational support</p> <p>Mesosystem</p> <p>Integrated leadership</p> <p>Consistent training</p> <p>Technology adoption</p> <p>Access to clinical practitioners</p>	<p>Outcomes in relation to Organisational Support</p> <p>Microsystem</p> <p>Lack of Clinical Support</p> <p>Mesosystem</p> <p>Technology Gaps</p> <p>Training shortfalls</p> <p>Leadership Gaps</p>
<p>Outcomes in relation to working relationships</p> <p>Microsystem</p> <p>Thriving connections</p> <p>Families</p> <p>Staff wellbeing</p>	<p>Outcomes in relation to Working Relationships</p> <p>Microsystem</p> <p>Resistance to full collaboration</p> <p>Mesosystem</p> <p>Variation in commitment to shared outcomes</p>
<p>COVID implementation</p> <p>Microsystem</p> <p>Early implementation (workforce changes)</p> <p>Enhanced operational practice in Care Homes</p> <p>Nominated GP and or Nurse</p> <p>Mesosystem</p> <p>Policy supporting practice</p> <p>Effective processes for care planning</p>	<p>COVID implementation</p> <p>Microsystem</p> <p>Care home sector receptivity</p> <p>Mesosystem</p> <p>Command and control</p> <p>Poorly operationalised care planning</p> <p>Poor responsiveness to pandemic</p> <p>Poor equipment and resourcing</p>
<p>Outcomes in relation to systemic perceptions</p> <p>Macrosystem</p> <p>Recognition of care home sector in public</p> <p>Changing perceptions within care sector</p>	<p>Outcomes in relation to systemic perceptions</p> <p>Microsystem</p> <p>Poor Care Home workforce wellbeing</p> <p>Mesosystem</p> <p>Misunderstanding of service offers</p>
<p>Outcomes in relation to communication</p> <p>Microsystem</p> <p>Accessibility of all staff (in relation to resident need)</p> <p>Mesosystem</p> <p>Enhanced engagement</p> <p>Enhanced collaboration across health and care home sector</p> <p>Macrosystem</p> <p>Enhanced formal communication processes</p>	<p>Outcomes in relation to communication</p> <p>Microsystem</p> <p>Reduced communication</p> <p>Mesosystem</p> <p>Lack of guidance (enhanced support offer)</p> <p>Macrosystem</p> <p>Lack of formal guidelines</p>

connections and relationships as assets and begins to highlight where further improvements in provision can be made.

The microsystems (local) level also highlights that some care homes reported no additional clinical support. The level of variation in EUSO across the region was great, suggesting a highly complex relationship between the strategic and operational activity and a continuum of enablers and inhibitory factors related to the context. For instance, at meso-system, there were examples of lack of guidance, poorly operationalised care planning and in some cases a ‘top down’ approach that was not well received by care home managers, this contrasted with the aforementioned positive leadership processes that were perceived as beneficial ways of supporting care homes during the pandemic.

4 | DISCUSSION

The evaluation, enabled by a group of senior managers across the health, care and public sector aimed to identify how the EUSO program had impacted across the region. For many, the severe effect of

the pandemic on care homes resulted from a late response from the health and care sector (Spilsbury et al., 2020). Whilst the context and time-frames were critical (Whitney & Cooperrider, 2011) and challenging, the recognition of achievement was important to teams and potentially transformative (Drucker, 2009). Stakeholders were able to demonstrate how organisations collaborated to improve quality of provision (Riege & Lindsay, 2006) and there is evidence to suggest that a shared vision and goals, together with recognition of practice innovations contributed to integrative practices (Amador et al., 2016).

A systems perspective to understanding the impact of the EUSO was useful insofar as it enabled the senior stakeholders to realise the interdependence of ‘levels’ (meso, macro and micro) in delivering the benefits. The evaluation suggests that there was stimulus at each level to compel organisations to act; policy to bring about rapid improvement, regional and sub-regional organisational agreements, and new collaborations and hyperlocal service negotiations and new practices. The EUSO, in some areas, accelerated the change that was in progress and in others highlighted where serious gaps existed. Integration of services is acknowledged to be difficult and generally

takes longer to deliver than expected (Rumbold & Shaw, 2010), but the regional response directed ultimately at the care home microsystem demonstrated horizontal integration at scale and pace with stringent vertical reporting measure to track progress.

Many of the barriers to commissioning and financing integrated services continue to exist (Wilding, 2010) perhaps because no coherent policy or consensus exists about the best arrangements for the care home sector (Goodman et al., 2016). The sustainability of the EUSO impact was not investigated but there were suggestions that strategies that support collaboration between visiting health care professionals and care home staff enable communication. The addition of some digital communication methods was clearly helpful during the pandemic and is being reported in research literature (Read et al., 2020). In keeping with previous suggestions, a sustained approach to transformation is needed in workforce, funding models, technology adoption and integrated care (Smith & Tantum, 2017). Care Home 'Vanguards' (2015–18) were inter-agency collaborative initiatives to improve care homes (Didehva et al., 2020) building capability and shared learning across the care home sector (Starling, 2018). Some areas in the region appeared to capitalise on their more established systems leadership practices as a result.

This study re-enforces that suggestion that; quality of health and care may depend on the presence of co-operative relationships, consistent professional communication and a 'levelling up' of the esteem for the care home provider workforce (Davies et al., 2011). Previous research has reported that neither paying clinicians to do more in care homes nor investing in training is sufficient to achieve

better outcomes for residents (Goodman et al., 2016). It is now well accepted that integrated person-centred care depends on excellent team leadership (Kim et al., 2017; Smith et al., 2020; Warwick-Giles & Checkland, 2018) and a strategic commitment to integrated cross sector provision (Atwal & Caldwell, 2002). Furthermore, existing relationships which build trust between practitioners are found to support effective working (Gordon et al., 2018). This study re-confirms the interdependencies of leadership and working relationships across multiple systems levels and the need to focus on population health. These findings add to the literature and learning about how the care home sector might be supported to manage workforce turnover, develop new professional practices, and develop inter-sector and agency knowledge (Kozłowska et al., 2020). The EUSO presented an opportunity to reduce roles ambiguity, resolve conflicting priorities and enhance resources during a traumatic period for the care sector.

4.1 | Strengths and limitations

The EUSO programme and evaluation were undertaken during the COVID-19 pandemic and the data collection was expediently resourced. The planning, interviews and focus groups were conducted entirely online and there was a consequent loss of face-to-face contact with any participant, which may have sensitised the evaluators to other critical issues, particularly emotions and perceptions not revealed on-screen. Strengths of the project included enabling access to care home workers and others who may be regarded as

Enablers (do more)

Supportive and strong leadership – integrated and strong leadership from care home to CCG level

Building positive connections – nurturing already-established relationships with CH staff, medical providers and senior managers, as well as building positive new relationships with clear understanding and supporting wellbeing.

Early implementation of response – preparedness and anticipation of needs based on evidence and existing networking. Collaboration at every level with strategic prioritisation for improvements communicated to all providers.

Recognition of care home sector and collaboration – enabling rapid implementation and outcome and impact assessment and shared evaluation

Person-centred communication – a commitment to problem-solving and co-production around the resident and the care home population

Inhibitors (try to do less)

Lack of training – a focus on training which does not meet care home needs, and no support to implement this.

Missed opportunities for collaboration – varied commitment from CCGs or Local Authorities, with added issues such as lack of integration and mismatched expectations between care homes and other stakeholders.

'Command and control' – focus on deliverables that meet the health agenda without specific guidance from care homes about the timeliness or need for support. Slow and poorly operationalised response due to inadequate and sustained team building and structures

Misunderstanding of care home services and/or 'forced' collaboration – early relationship or mis-trust or reticence in place-based integration associated with care home sector. negative view of 'low-skilled' care works perpetuated with training model and resulting dependency and/or resistance.

Disorganised communication: Confused or lack of central guidance, teamed with the lack of communication to broadcast changes in a rapidly-changing situation.



FIGURE 1 Enablers and Inhibitors for future care home support programmes

more marginalised, whose perceptions and feedback on impact were included and used to inform more powerful stakeholders (Farrington, 2016). In addition, there was focus on the impact on the whole system rather than narrow measures, e.g. hospital utilisation (Rumbold & Shaw, 2010).

During the pandemic the EUSO had aimed to address population health with protection for care home staff and this element of the care home support has not been addressed in this evaluation, with very limited data that acknowledged the workforce wellbeing and scale of staff response in social care. Further work in pathway planning and evaluation is important for those with dementia and palliative care planning. Further attention may be needed to understand the support needs of residential and nursing home staff (Schols et al., 2020).

4.2 | Recommendations

As a result of the EUSO evaluation steering group co-production, enablers and inhibitors to best practice were generated (see Figure 1). Using the data, local knowledge and additional reference to the emerging literature associated with care homes during COVID-19, exemplary practice was recognised and could be shared across the region, as well as areas where leadership, resources and methods to sustain care home development were lacking.

Integrated systems leadership across health and local authorities are critical where the best outcomes were achieved. Figure 1 suggests that there was a continuum of improvement, based on systems-thinking, that might support care homes through integrated community provision.

5 | CONCLUSION

The evaluation reflects the perceptions of a range of stakeholders and re-confirms the need for consistent effective leadership and delivery of integrated care in association with the care home sector. Microsystem improvements were based on relationship, communication and new processes associated with technology and pharmacy practices. Unsurprisingly, interagency, cross sector and multidisciplinary relationship and communication led to better outcomes. Systems leadership is a critical factor in setting and sustaining the commitment to inclusion and representation of the care home sector as part of the health and care economy.

ACKNOWLEDGEMENTS

Charlotte Lambert, Quality Coordinator, Janet Bell, Project Support Officer Ageing well, Shion Gosrani, Public Health Support Officer; Yusef Qureshi, Graduate Management Trainee; Hannah Sharpe, Graduate Management Trainee; Rebekka Shenfine, Specialty Registrar in Public Health; Melissa Brown, Specialty Registrar in Public Health; James Breckwoldt, Graduate Management Trainee; Christina Cackett, Graduate Management Trainee. Also, Jenny

Sleight, NHS England and Improvement, Annie Topping NHS Northumbria Healthcare Trust, Penny Woodhead, NHS Greater Huddersfield CCG, Jeanette Scott, NHS South Tyneside CCG and Jeanette Cookson, Skills for Care.

CONFLICT OF INTEREST

None.

AUTHORS' CONTRIBUTIONS

SFD & RC drafted the original manuscript and GH, MP, HD and KC contributed to the analysis, editing and final submission, all authors contributed to the conceptualisation, design of the evaluation.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Sheffield Hallam University Ethics Committee Approval ID: ER26371908, August 2020 – Verbal consent was approved based on archived recording of virtual 'zoom' meetings. Participant consent was based on the researcher reading the participant information sheet and asking all participants to visually (nodding) and verbally approving their acceptance and consenting to participate on the recording. Written consent was not deemed to be necessary in addition to these measures and would have been impossible given the virtual mode of data collection.

CONSENT FOR PUBLICATION

Non applicable.

DATA AVAILABILITY STATEMENT

The datasets generated and/or analysed during the current study are not publicly available due to their being archived within the NHS and not by the University but may be made available from the corresponding author on reasonable request.

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How to cite this article: Fowler-Davis, S., Cholerton, R., Philbin, M., Clark, K., & Hunt, G. (2021). Impact of the Enhanced Universal Support Offer to Care Homes during COVID-19 in the UK: Evaluation using appreciative inquiry. *Health & Social Care in the Community*, 00, 1–11. <https://doi.org/10.1111/hsc.13612>