IFF Research

Escalation of Care survey findings

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Executive Summary (1 of 2)

- This research forms part of Module 3 of the UK Covid-19 Inquiry. It investigates decisions around escalating patients to the next level of care during the first two waves of the pandemic. It involved a survey of **1,683** healthcare professionals (HCPs) from a mix of roles and settings.

- Over half (58%) of HCPs reported that some **patients could not be escalated to the next level of care due to a lack of resources** during either wave of the pandemic. A&E doctors (71%) and paramedics (62%) were more likely to have ever been unable to escalate care due to a lack of resources at either wave.

- The primary reasons for the inability to escalate care were a **lack of available beds** at all levels, including high dependency units, **and a lack of staff** (overall or at the right level), followed by a lack of equipment or technology and lack of access to an ambulance.

- Four fifths (81%) of HCPs agreed that **more patients were unable to be escalated** during the pandemic compared to before and over two thirds (71%) agreed that patients who were unable to be escalated were **more severely ill**.

Executive Summary (2 of 2)

- During each wave of the pandemic, 1 in 3 HCPs said they **received instructions from their employer on which groups should not be escalated** to the next level of care, although this was the case for a majority of paramedics (55%). About half of HCPs felt supported by their employer to make decisions about escalation of care, but only a **minority felt well-supported** by their professional organisation, trade unions, regulatory bodies or National NHS authorities.

- Over two thirds of HCPs (69%) felt they had **insufficient staff at their place of work to provide good quality patient care** at least weekly during the pandemic. This was significantly higher than 43% who experienced this pre-pandemic.

- Most HCPs (80%) reported **having to act in ways that conflicted with their values** during the pandemic. Critical care nurses (92%) and paramedics (84%) were more likely to report these conflicts, with 58% of critical care nurses indicating they faced this issue daily.

- There was a call for clear, consistent, data-driven guidance and supportive management who acknowledge the challenges involved and protect staff from unfair criticism for decisions.

Introduction

Background

The UK Covid-19 Inquiry's terms of reference include understanding the impact of the pandemic on patients and healthcare staff.

IFF Research was commissioned to conduct a survey of healthcare professionals (HCPs) as part of **Module 3, which focuses on the healthcare systems of the UK**, and specifically their ability to increase critical care capacity, the triage of patients, and the role of primary care.

Research focus

The research focuses on **decisions around escalating patients to the next level of care** during the first two waves of the pandemic**.**

The survey specified that this would include decisions around whether to:

- call patients an ambulance or send them to hospital;
- accept patients onto a hospital ward;
- transfer or admit patients to critical care.

Research topics

The research explores:

- how often healthcare professionals were unable to escalate care due to a lack of resources during the pandemic,
- what resources, if any, were lacking,
- support and guidance provided around these decisions,
- how often there were insufficient staff to provide good quality patient care, and
- how often staff had to act in conflict with their values.

Approach: Sampling

Eight groups of healthcare professionals were identified as likely to have particularly pertinent experiences of the escalation of care:

- Critical care doctors
- Critical care nurses
- A&E doctors
- Hospital ward doctors
- GPs
- Paramedics
- 111 call handlers
- 111 health advisors

For the groups above, contact details of 15,573 HCPs were sourced from the Wilmington healthcare database. For Hospital ward doctors, records were drawn from 13 core specialities.

After 4 weeks of fieldwork, a top up of 2,701 HCP records were drawn for hospital ward doctors, due to a lower response from this group, in part because many of the doctors included in this sample had ended up being classified as 'critical care doctors' or 'A&E doctors' instead.

Where contact details weren't available, an open link was also shared through Core Participant organisations (CPs):

- Welsh Ambulance Service
- Northern Ireland Ambulance Service
- Scottish Ambulance Service
- London Ambulance Service
- North East Ambulance Service
- West Midlands Ambulance Service
- College of Paramedics

Snowballing: At the end of the survey, HCPs were asked to provide their email and sent an invitation to the survey, which they were asked to forward to suitable colleagues. This link was also used to share with professional networks.

Approach: questionnaire development

Questionnaire

An initial questionnaire was developed with the UK Covid-19 Inquiry research team and reviewed by nine clinical academics acting as independent expert witnesses.

Questions were included to ensure HCPs were working in the UK during the pandemic and were involved in or witnessed escalation decisions.

The first wave was defined as approximately **March 2020 to May 2020**, with the second wave dated as approximately **October 2020 to March 2021**.

Pilot

The pilot was used to check the length of the survey, respondent understanding, and the comprehensiveness and relevance of the questionnaire.

An email invite was sent to 10% of the sample for critical care doctors, critical care nurses and A&E doctors and to 20% of GPs and hospital doctors to ensure a good spread of responses within the time available.

The pilot survey was completed by 40 HCPs.

Cognitive testing

Cognitive testing was used to check comprehension and relevance of the survey. Six interviews were completed: one GP, three medical doctors based on hospital wards, and two critical care doctors.

The cognitive testing showed that the questionnaire was well understood in general. Some small amends were made to wording and an additional question added.

Key amends

- Added question on employer guidance on escalation decisions
- "Not applicable" was added to the question on support from organisations
- CPs also asked for 999 call handlers to be added to the list of roles in the survey. 14 respondents who identified as 999 call handlers were included in the final results.

Approach: recruitment

Survey fieldwork

The online survey was completed by **1,683** HCPs between 13th May to 24th June 2024.

- Wilmington Healthcare sample (702)
- CP open links (702)
- Referral/Snowballing link (279)

The Wilmington Healthcare sample were invited by email. Non-responders were sent up to 4 reminders and the final response rate was 4%.

The median survey length was 9 minutes.

Achieving targets

The final number of responses achieved for 111 call handlers or health advisors was not enough to allow separate analysis of these groups' experiences.

Low response from the 111 workforce is likely to be due to staff turnover and some feeling that they were out of scope of the research due to not making escalation of care decisions.

Verbatim role descriptions were reviewed to remove HCPs not in scope. Five records were identified and removed.

Sample sizes

A good spread of responses was achieved by role and country. There was some overlap between roles.

Role Summary

- Paramedics (n=579)
- Critical care doctors (n=342)
- GPs (n=249)
- Hospital ward (n=232)
- Critical care nurses (n=158)
- A&E Doctors (n=136)
- Other (n=158)

Country

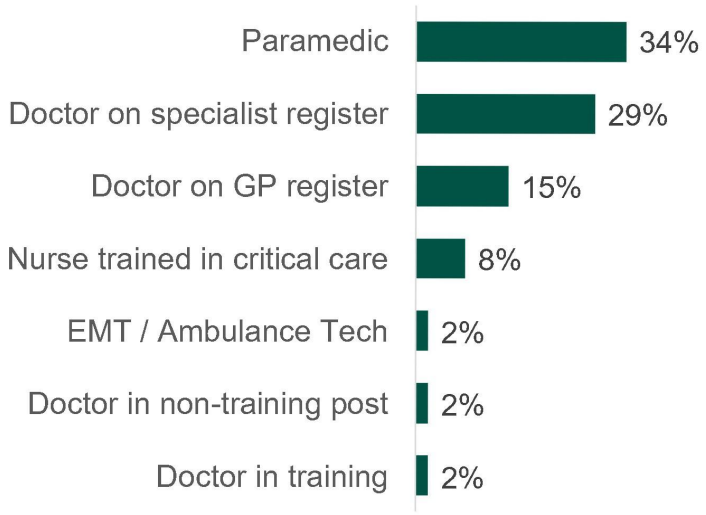
- England (n=1367)
- Scotland (n=138)
- Wales (n=110)
- Northern Ireland (n=64)

Who took part? Respondent profile

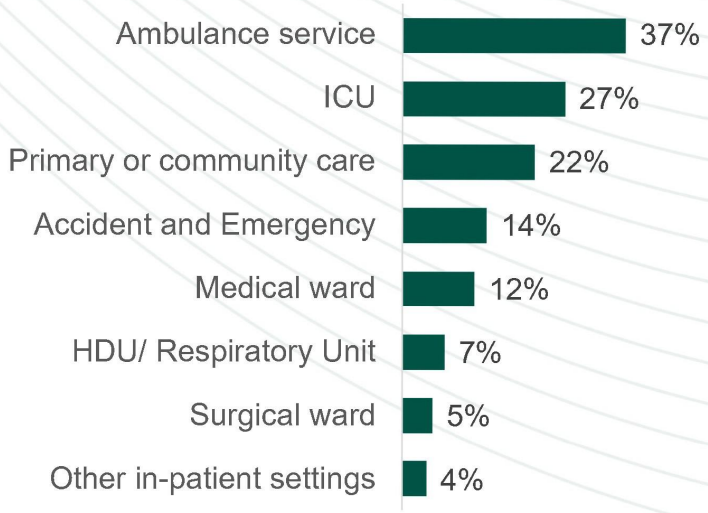
Profile of healthcare professionals (HCPs)

Healthcare professionals from a mix of roles and settings completed the survey.

Job Role



Clinical Setting



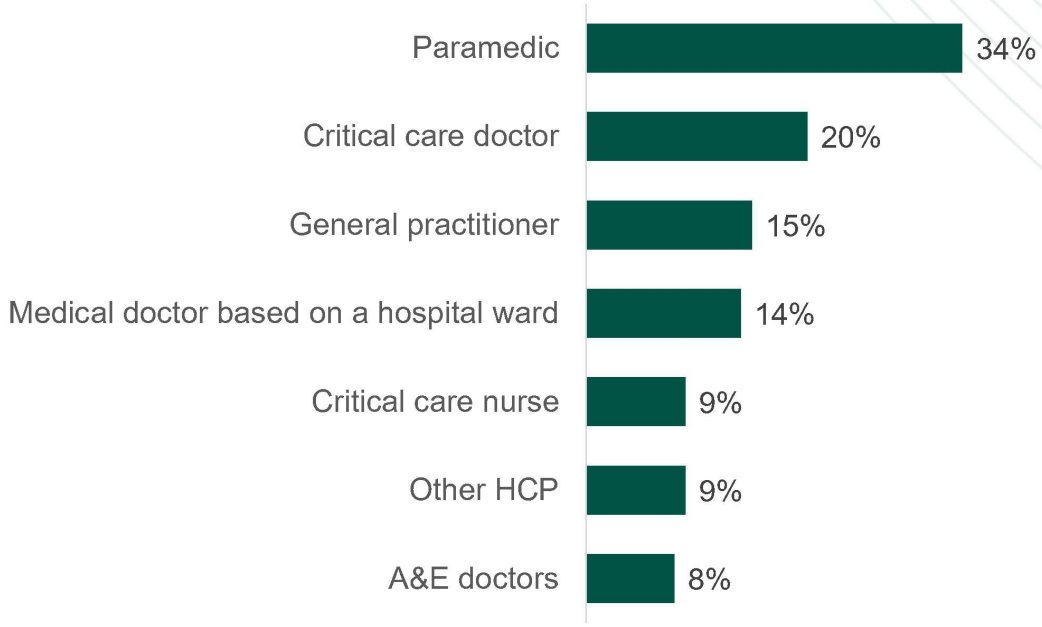
- 1% each: critical care outreach nurses, nurses not trained in critical care, and advanced practitioners
- <1% each: 999 call handlers, 111 call handlers, 111 clinical advisors

A3 Which of these best describes your job role during that time? A4 Which type(s) of clinical settings did you work in during the pandemic? All healthcare professionals (**1,683**)

Profile of healthcare professionals (HCPs)

The roles were summarised for analysis, based on both role and clinical setting.

Role summary (mix of role and setting)



There was significant overlap between the roles. 45% of doctors based on hospital wards and 37% of A&E doctors were also critical care doctors.

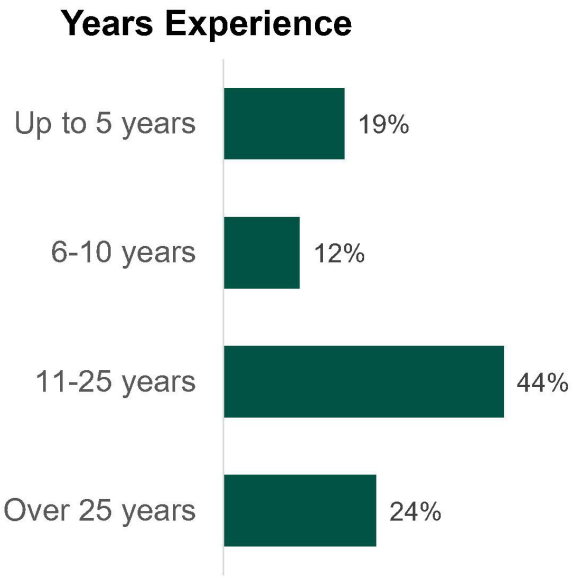
Critical care doctors were more split by setting than other roles – 83% ICU, 27% HDU, 20% medical ward

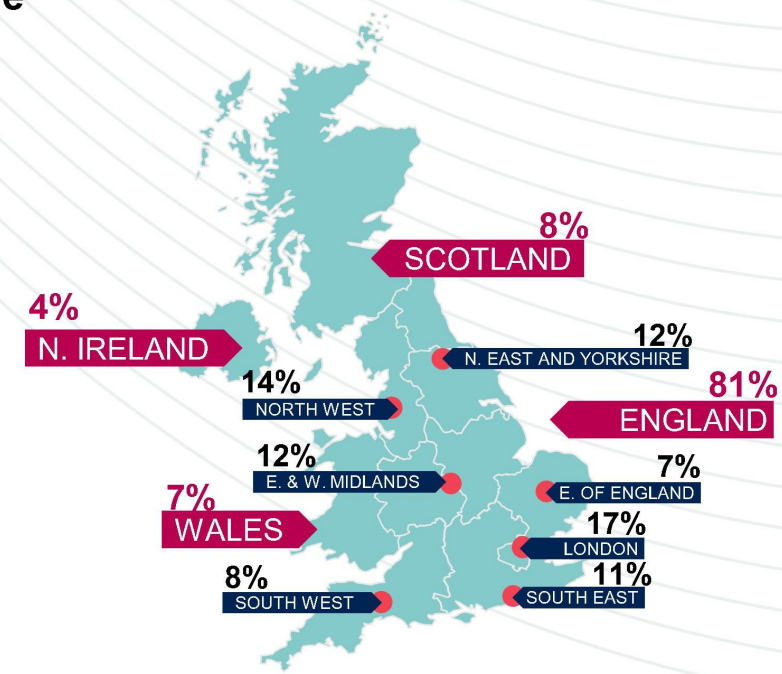
Those in “other HCPs” included specialists working in non-hospital settings, and ambulance workers who were not paramedics. The majority worked in the ambulance service (53%) or primary/community care (24%)

A3 Which of these best describes your job role during that time? A4 Which type(s) of clinical settings did you work in during the pandemic? All healthcare professionals (**1,683**)

Profile of healthcare professionals (HCPs)

Most HCPs had 11 years or more experience (68%). A wide geographic spread of responses was achieved.





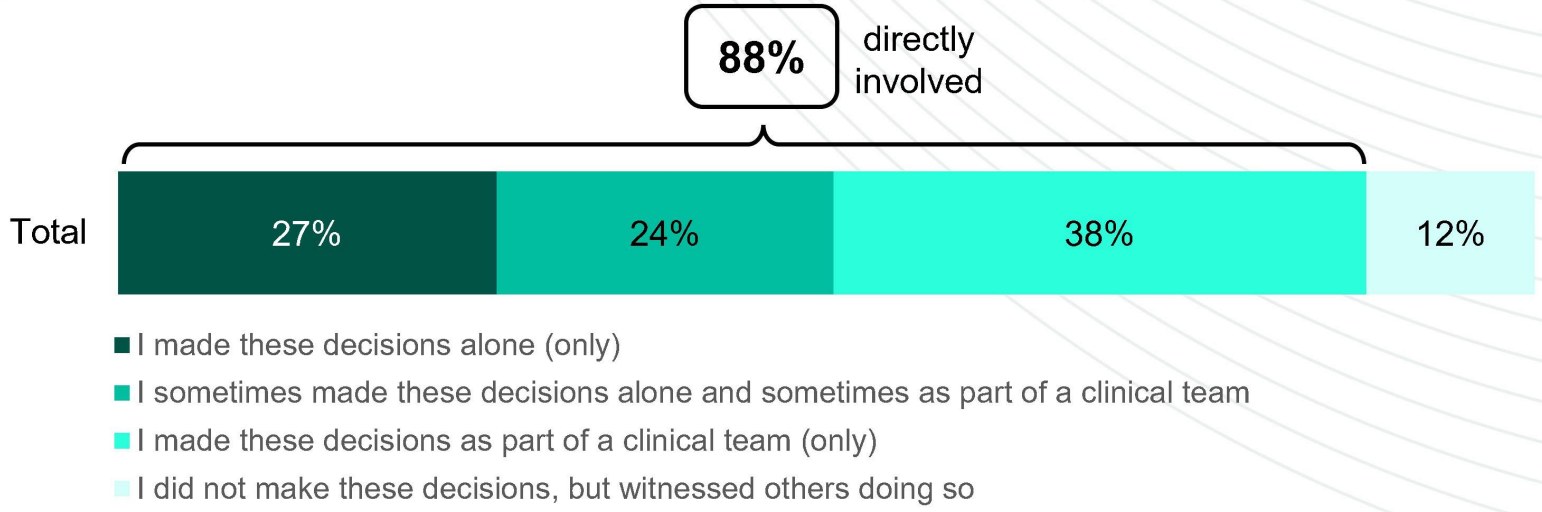
- Most of those with 5 or fewer years' experience were paramedics (75%)

- Paramedics formed a larger proportion of respondents in Northern Ireland (50%) and Wales (45%) than England (34%) or Scotland (29%).
- Within England, paramedics were more common than average in the Midlands (41%) and North East / Yorkshire (41%)

A5 How many years had you been practising at the start of the pandemic? / A2 Which part of the UK did you spend the most time working in during the pandemic? All HCPs (**1,683**)

Responsibility for decisions

88% of HCPs surveyed were directly involved in making escalation decisions, with 12% just witnessing these decisions.



- GPs (84%) and paramedics (73%) most commonly made escalation decisions alone
- Critical care nurses (59%) and other HCPs (32%) were more likely to have witnessed but not made escalation decisions.

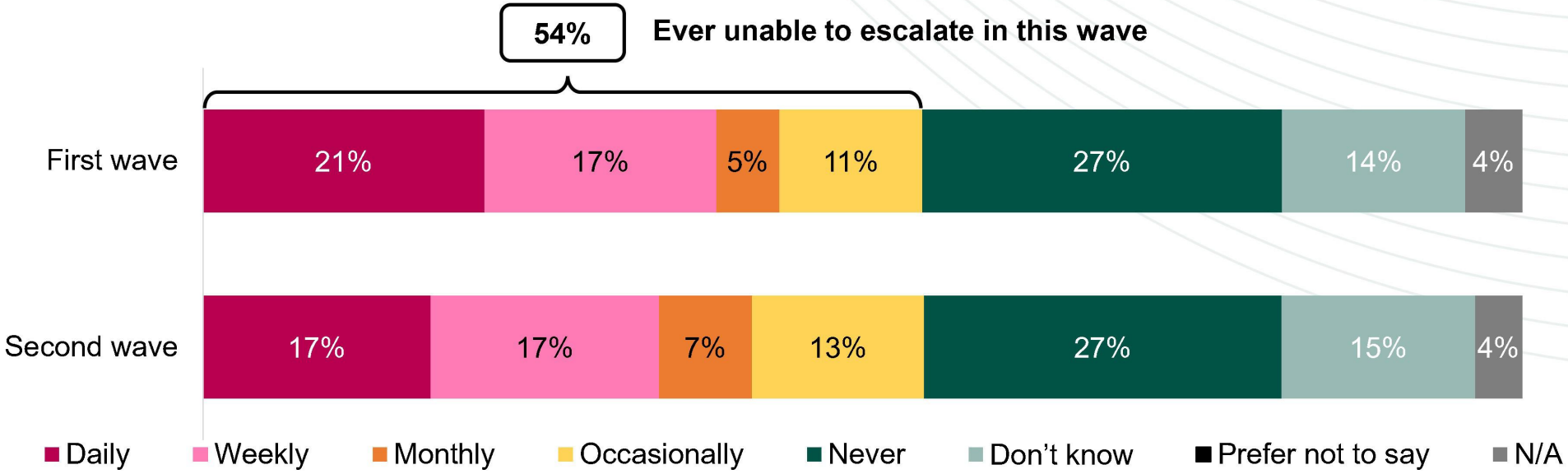
A6. Were you involved in decisions around escalating patients to the next level of care during the pandemic? All HCPs (**1,683**)

Experiences of escalation of care

Frequency of inability to escalate

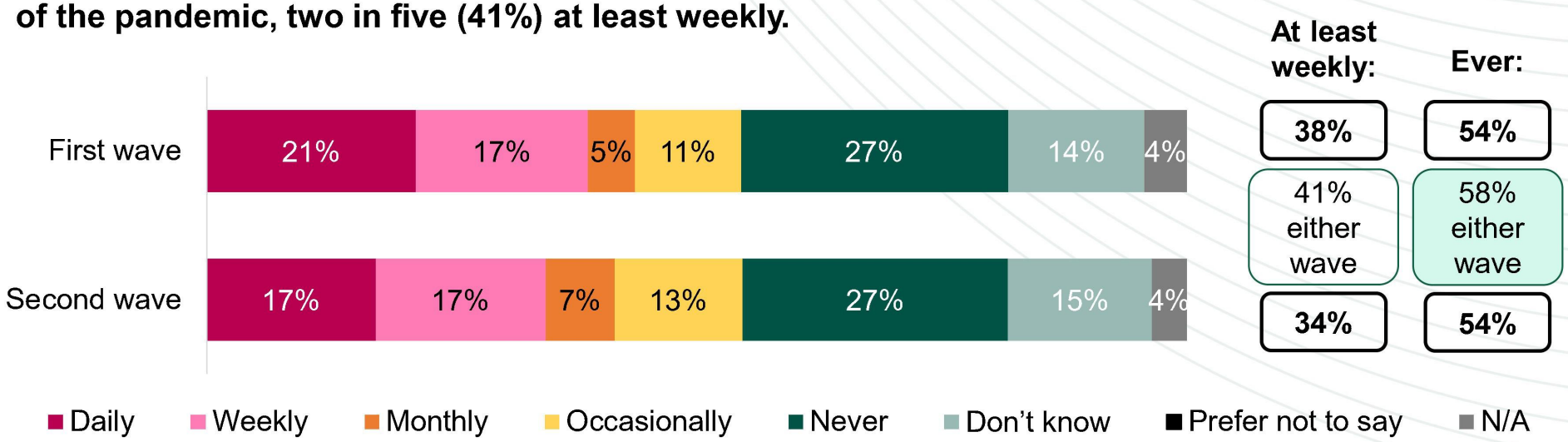
All **1,683** healthcare professionals surveyed were asked the following about escalation decisions they were involved in or witnessed first hand: ***"How often, if at all, were any patients unable to be escalated to the next level of care due to a lack of resources?"***

For both the first and second waves of the Covid-19 pandemic, over half (54%) of respondents reported that some patients could not be escalated to the next level of care due to a lack of resources.



Frequency of inability to escalate (detailed)

Over half (58%) of healthcare professionals reported that some patients could not be escalated to the next level of care due to a lack of resources during either wave of the pandemic, two in five (41%) at least weekly.



	At least weekly:	Ever:
First wave	38%	54%
Either wave	41%	58%
Second wave	34%	54%

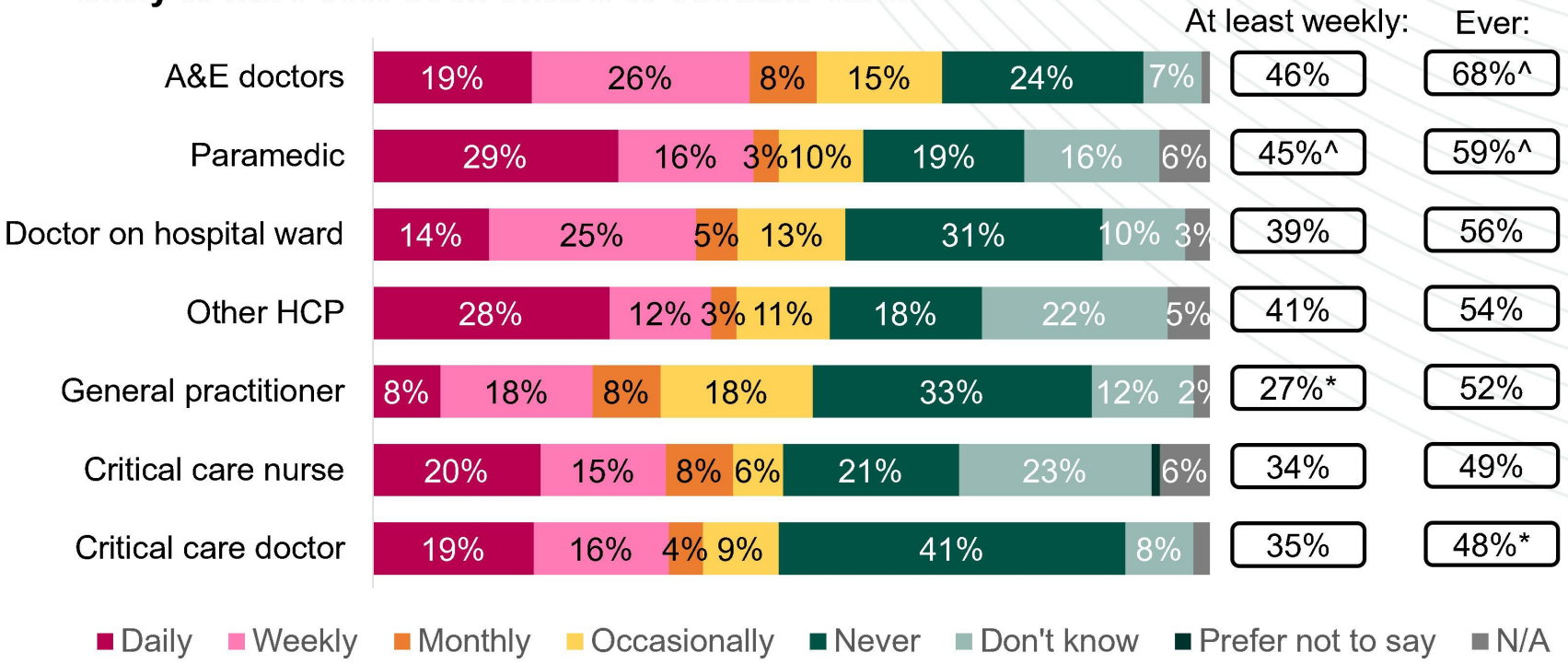
Those in London (73%) or East of England (68%) were more likely to have been unable to escalate care during either wave, while those in the Midlands (49%) and the North West (50%) were less likely.

Those who only witnessed decisions were more likely to say they don't know (30% wave 1 and 30% wave 2), compared to those involved in decisions (12% wave 1, 13% wave 2).

B1. How often, if at all, were any patients unable to be escalated to the next level of care due to a lack of resources? All HCPs (**1,683**)

Frequency of inability to escalate by role

During the <u>first wave</u>, A&E doctors and paramedics were significantly more likely to have ever been unable to escalate care.



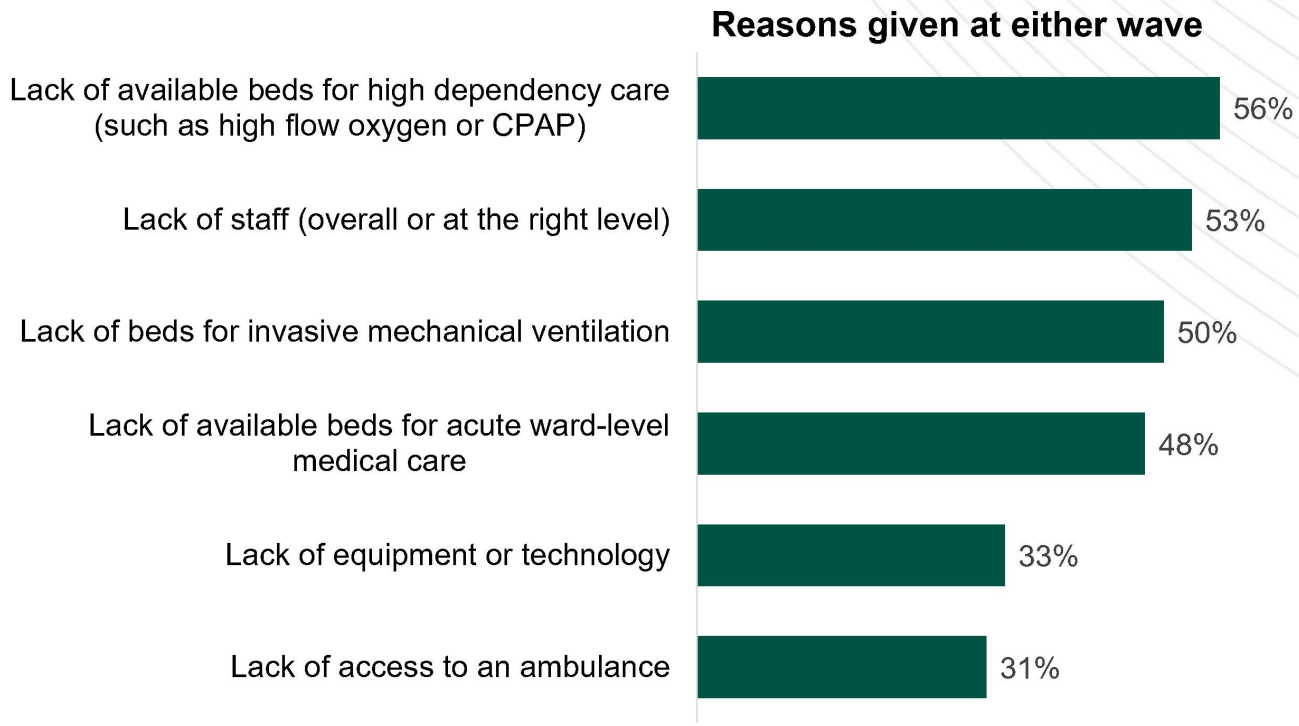
Frequency of inability to escalate care by role remained broadly similar for the second wave of the pandemic.

17 B1. How often, if at all, were any patients unable to be escalated to the next level of care due to a lack of resources?
All HCPs (**1,683**)

^ significantly higher than the average of other groups
** significantly lower than the average of other groups*

Reasons for difficulty escalating

A lack of beds was the most common reason for being unable to escalate care, along with a lack of staff.



Lack of beds (summary): **78%**

Additional reasons added spontaneously by respondents included:

- Adherence to covid restrictions or guidelines (7%)
- Reluctance to escalate older patients / care home residents (2%)
- Patients being unwilling to go to hospital (2%)
- Lack of availability in A&E / resus (1%)
- Lack of PPE (1%)
- Rapidly changing escalation policies (1%)

B2. Which of the following reasons contributed to you being unable to escalate care during the first wave of the pandemic? All who were unable to escalate at least occasionally in either wave (**971**)

Reasons for difficulty escalating by role

Barriers to escalation of care differed according to role, particularly by type of bed needed and access to an ambulance.

	Overall	GP	Para-medic	Critical care nurse	Critical care doctor	A&E doctor	Medical ward doctors	Other HCP
Lack of available beds for high dependency care (such as high flow oxygen or CPAP)	56%	28%*	54%	62%	73%^	76%^	79%^	42%*
Lack of staff (overall or at the right level)	53%	35%*	58%^	62%	61%^	45%	48%	54%
Lack of available beds for invasive mechanical ventilation	50%	20%*	40%*	85%^	80%^	71%^	66%^	39%*
Lack of available beds for acute ward-level medical care	48%	59%^	58%^	27%*	32%*	45%	43%	48%
Lack of equipment or technology	33%	20%*	33%	45%^	43%^	31%	32%	34%
Lack of access to an ambulance	31%	55%^	45%^	4%*	5%*	7%*	3%*	53%*

B2. Which of the following reasons contributed to you being unable to escalate care during the first wave of the pandemic? All who were unable to escalate at least occasionally in either wave (**971**)

^ significantly higher than the average of other groups
** significantly lower than the average of other groups*

Escalation before and during the pandemic (1 of 2)

A large majority (81%) agreed that <u>more patients</u> were unable to have their care escalated compared to the 12 months before the pandemic.

Total Agree:	Total Disagree:
81%	7%

■ Strongly agree ■ Agree ■ Neither agree nor disagree ■ Disagree ■ Strongly disagree ■ Don't know ■ N/A

Paramedics were more likely to strongly agree (55%).

HCPs in London (91%) were more likely to agree or strongly agree, with 67% strongly agreeing.

> *This was extremely difficult and upsetting knowing not all patients that may have been accepted to ICU on any normal day could not be accepted during the pandemic. We were outnumbered and had no choice and admitted the patients who met the criteria.*
>
> **Critical care nurse, North West**

B4.To what extent do you agree with the following statements? All who were unable to escalate at least occasionally in either wave (**971**)

Escalation before and during the pandemic (2 of 2)

A majority (71%) agreed that during the pandemic, the patients they were unable to escalate were <u>more severely ill</u> compared to the 12 months before.

Total Agree:	Total Disagree:
71%	9%

Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree | Don't know | N/A

Critical care nurses were more likely to agree or strongly agree (82%).

Those in London (81%) were more likely to agree or strongly agree.

As a paramedic working for the ambulance service, I was advised to use different physiological parameters to contribute to discharging care at home - patients were being left at home with lower oxygen levels than would be acceptable pre-pandemic.

Paramedic

B4.To what extent do you agree with the following statements? All who were unable to escalate at least occasionally in either wave (**971**)

Examples of experiences escalating care

Some people weren't escalated as per norm because we wanted to save bed space for those that might survive.

Paramedic

[There is] a perception that we needed to limit availability due to a risk of being overwhelmed. We had high admissions but I think some borderline escalation patients were denied care they would have got prior to the pandemic.

A&E doctor, North West

Where I work, there was always enough capacity to admit patients who had been escalated and a clear set of criteria by which to do so. The process went smoothly during both waves, but with some waiting to get in during the second wave.

Paramedic

We knew it wouldn't help because we had come to see what kind of people died of this disease [Covid-19] despite escalated care. So we decided not to admit to critical care whereas had they had a different illness, they probably would have been more likely to benefit so we would have escalated. We didn't have enough space to 'give people a go' who had a very remote chance of getting better. If we had had more capacity, we might have been in a position to try.

Critical care doctor, Wales

"Many patients that did remain at home because of the guidance would have typically been taken to hospital urgently under non-pandemic conditions. Additionally, some patients who required hospital would not want to go for fear of catching Covid."

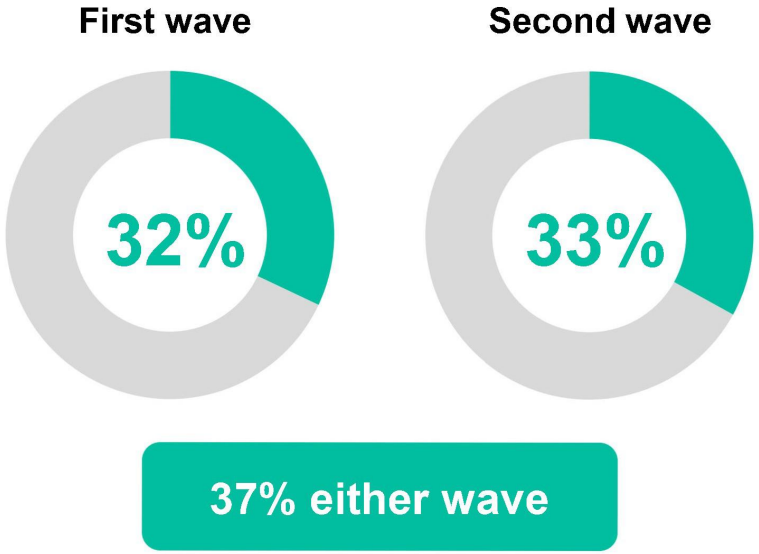
Paramedic

B9. Anything else you would like to share with us about escalation of care decisions during the pandemic… All HCPs (**1,683**)

Support and guidance

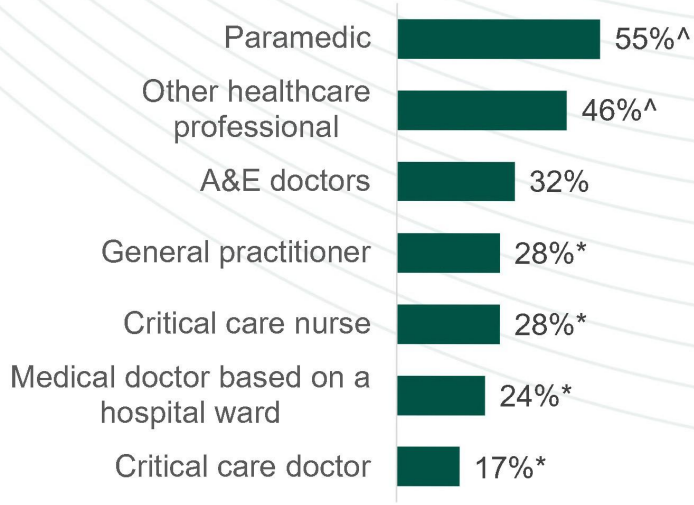
Instructions from employers

During each wave of the pandemic, 1 in 3 HCPs said they received instructions from their employer on which groups should not be escalated to the next level of care.



However, this differed significantly by role, with a majority of paramedics likely to receive employer instructions.

Either wave, by role:

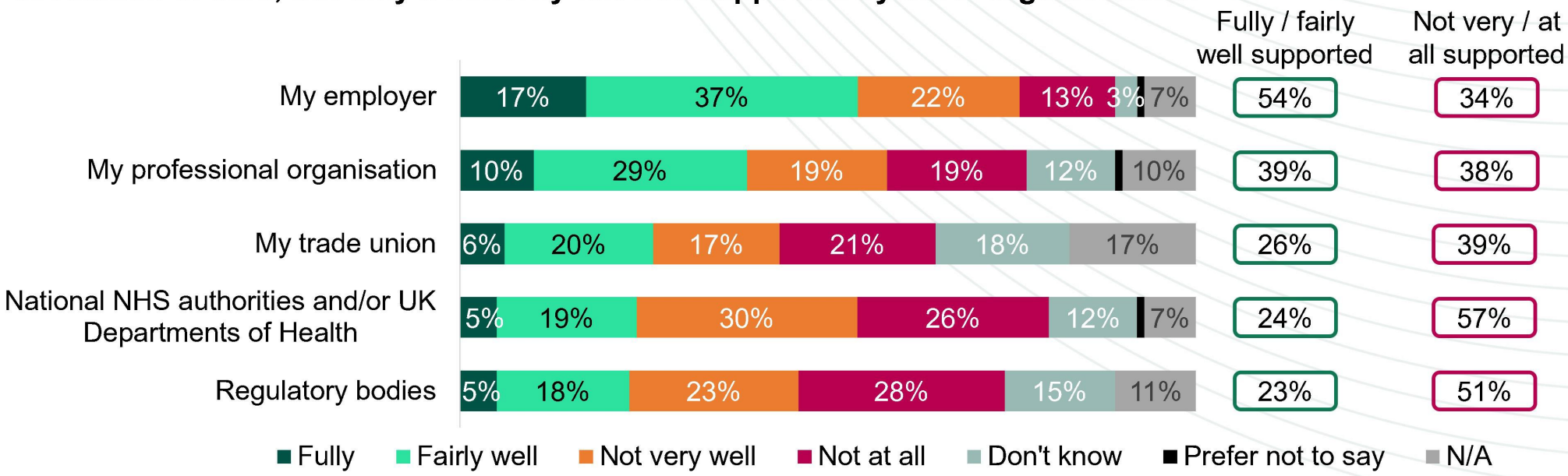


B4A. Did your employer issue instructions on groups which should not be escalated to the next level of care during the first or second wave of the pandemic? All HCPs post-pilot survey (**1,636**)

^ significantly higher than the average of other groups
** significantly lower than the average of other groups*

Support from organisations

About half of HCPs felt supported by their employer to make decisions about escalation of care, but only a minority felt well supported by other organisations.



High rates of 'don't know' may be due to respondents being unsure how these organisations could or should support them.

High rates of 'not applicable' may be due to some of these organisations not being relevant for all (e.g. trade unions). A higher proportion of GPs selected 'not applicable' for 'my employer' (23%), likely due to some GPs running their own practices.

B5. To what extent (if at all) did you feel supported to make decisions about escalation of care by the following organisations? All HCPs (**1,683**)

Support from organisations by role

Critical care nurses, paramedics and other healthcare professionals were less likely to say they feel fully or fairly well supported by different organisations.

	Overall	GP	Para-medic	Critical care nurse	Critical care doctor	A&E doctor	Medical ward doctors	Other HCP
My employer	54%	54%	51%	45%*	62%^	66%^	62%^	41%*
My professional organisation (e.g. relevant Royal Colleges)	39%	37%	31%*	28%*	60%^	68%^	44%	16%*
My trade union (e.g. British Medical Association)	26%	39%^	27%	12%*	30%	28%	26%	13%*
National NHS authorities and/ or UK Departments of Health	24%	28%	25%	15%*	25%	29%	22%	18%
Regulatory bodies (e.g. General Medical Council)	23%	23%	22%	22%	27%^	30%^	23%	11%*

B5. To what extent (if at all) did you feel supported to make decisions about escalation of care by the following organisations? All HCPs (**1,683**)

^ significantly higher than the average of other groups
** significantly lower than the average of other groups*

Additional desired support

Healthcare professionals had a range of ideas for what would have improved their confidence in making escalation of care decisions:

Guidance / advice / escalation criteria (25%), including…	Support from management / authorities (14%), including…	Resources / equipment / staffing (9%), including…	Other
Clearer guidelines / criteria (14%)	Better advice / support with decisions (6%)	More resources / equipment (4%)	More efficient pandemic response / support in place sooner (4%)
Consistent escalation policies between local healthcare providers / nationally (5%)	Greater acknowledgement of the challenges involved (5%)	More / better quality PPE (3%)	Better communication between different parts of the healthcare system (3%)
More data / information available (4%)	Better access to staff / more senior staff onsite (3%)	Greater capacity / availability of beds (3%)	Fewer restrictions on escalation decisions (2%)
Guidance changing / updating less frequently (4%)	Better protection against unfair criticism of escalation decisions (3%)	More staff / help with staffing (2%)	Alternative care options (1%)
More evidence-based policies / knowledgeable decision-makers (3%)			

B6. What additional support or guidance would have helped your confidence in making escalation of care decisions during the pandemic? Base: all who did not feel fully supported by all types of organisation (**1,481**).

Examples of additional desired support

IFF Research

Clearer guidelines / criteria (14%)

*Some clarity on triaging if capacity was overwhelmed would have been useful. What we got was **vague and not very practical**, it all felt based on the hope that it would not be needed.*

Critical care doctor, Midlands

Better advice / support with decisions (6%)

***I felt we were working in isolation** in the community with national support and guidance solely focused on secondary care. GPs including myself were having to make very tough advanced care plans with families in their homes and had difficulty accessing medications and community team input to support.*

GP, Wales

More data / information available (4%)

*We needed **better information about community prevalence of Covid infection and knowledge about who was likely to deteriorate**. Luckily, my husband is an ITU consultant, so I shared the really helpful ICNARC* with my primary care colleagues when our college was not able to share useful information. More community testing would have been helpful in the early stages.*

GP, Midlands

Better communication between different parts of the healthcare system (3%)

***The guidance paramedics followed did not always correlate with hospitals** and so on arrival at hospital there was often push back to accept some patients.*

Paramedic

Alternative care options (1%)

***More structure for patients and members of the public for how to look after themselves** at home with minimal symptoms. For extra services to have been open to see their own patients, as **GP practices in my area would not see patients face to face**, which impacted the ambulance service massively and to this day is still affecting us as emergency workers.*

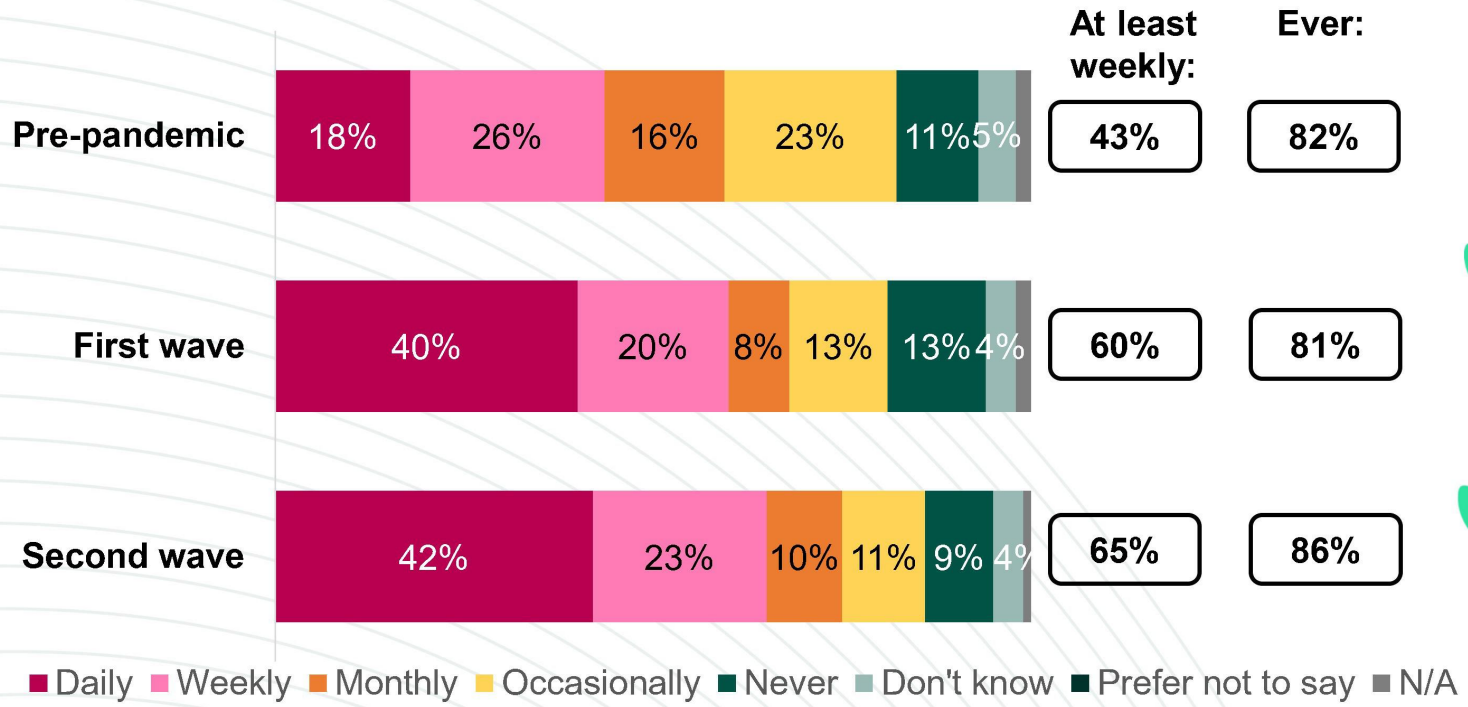
Paramedic

B6. What additional support or guidance would have helped your confidence in making escalation of care decisions during the pandemic? Base: all who did not feel fully supported by all types of organisation (**1,481**). *ICNARC: Intensive Care National Audit and Research Centre

Quality of care and conflict with values

Insufficient staff to provide good quality care

More than two-thirds (69%) felt they had insufficient staff at their place of work to provide good quality patient care at least weekly, compared to less than half (43%) in the 12 months before the pandemic.



More likely at least <u>weekly</u> either wave:

- Critical Care nurses (90%)
- Paramedics (73%)
- This compares to 69% of all HCPs

- Working in London (84%) compared to 69% of all HCPs

B7 SUMMARY. How often, if at all, did you have insufficient staff at your place of work to provide good quality patient care… All HCPs (**1,683**)

Insufficient staff to provide good quality care

One in ten healthcare professionals shared views, unprompted, about patients receiving poor quality care, with a further 5% mentioning staffing issues.

Poor quality care (10%)

- Patients were denied care / died as a result of escalation policies (5%)
- Patients received no / limited care if elderly or deemed unlikely to survive (3%)
- Patients in hospital did not receive a suitable standard of care (2%)
- Patients left in / sent back to care homes should have been in hospital (2%)

Those in London (16%) were more likely to report poor quality care issues

Not enough staff / suitably trained staff (5%)

Critical care nurses (16%) and critical care doctors (11%) were more likely to report a lack of (suitably trained) staff

Those in the North West (11%) were also more likely to report staffing issues

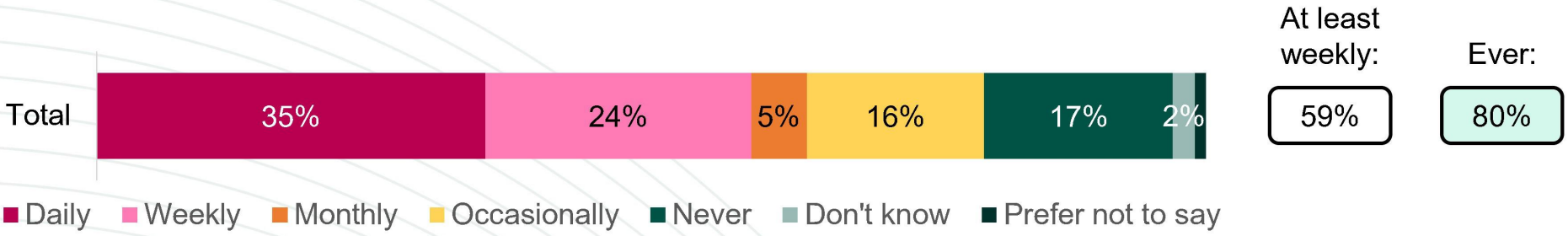
*We made it work by cancelling elective operations and **diluting staffing** (1:4). Most people who needed critical care during pandemic received it because everyone was working flat out expanding capacity and because the **quality of care was being diluted** significantly from pre-pandemic standard. This was reflected in a **significantly higher mortality.***

Critical care doctor, London

B9. Anything else you would like to share with us about escalation of care decisions during the pandemic… All HCPs (**1,683**)

Acting in conflict with values during the pandemic

Four fifths (80%) said they had to act in a way that conflicted with their values when at work during the pandemic, with three fifths experiencing this at least weekly.



Unprompted comments relating to acting in conflict with values:

- Escalation was handled well within the trust / patients received the appropriate care (6%)
- Difficult escalation decisions had an emotional impact (5%)
- Did not agree with escalation policies (2%)

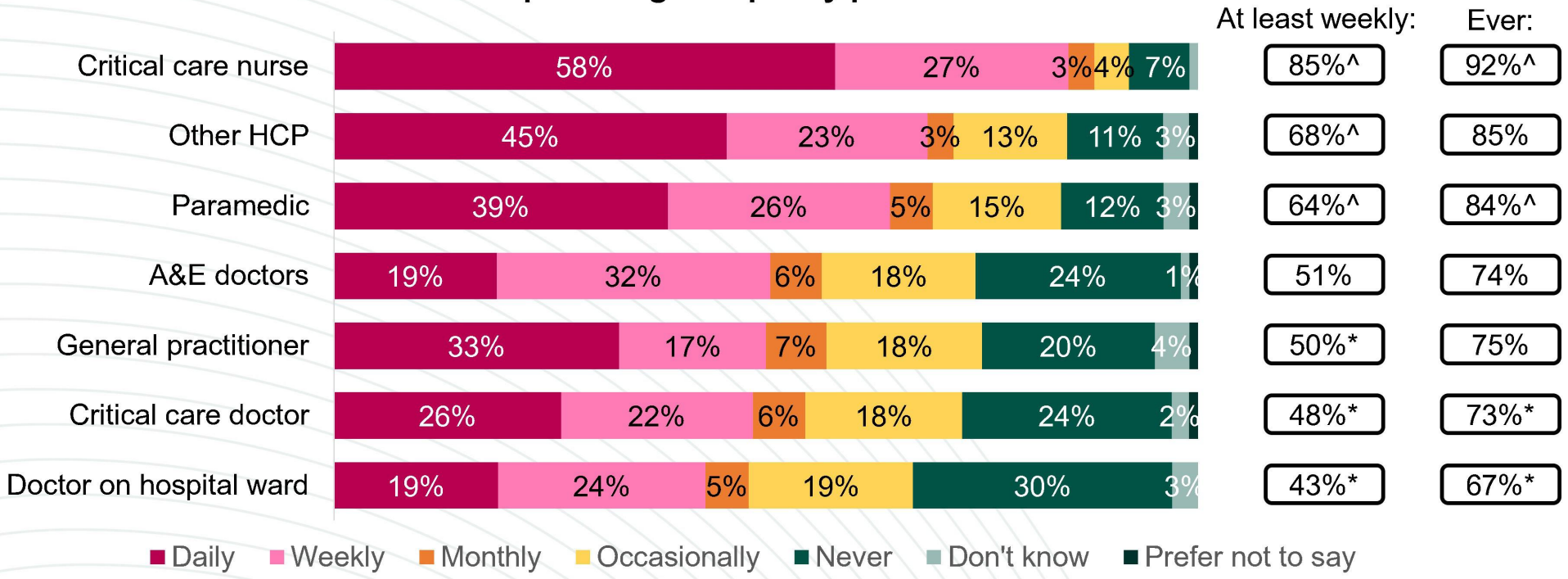
Those who reported that patients could not be escalated to the next level of care due to a lack of resources at either wave were more likely to have had to act in a way that conflicted with their values (89%) as were those who received escalation instructions from employer (88%)

Those working in London were also more likely to have to act in conflict with their values (88%)

B8. How frequently, if at all, did you have to act in a way which conflicted with your values when at work during the pandemic? All HCPs (**1,683**)

Acting in conflict with values by role

Critical care nurses were particularly likely to report having to act in a way which conflicted with their values when at work during the pandemic, likely linked to the higher proportion feeling that there were insufficient staff to provide good quality patient care.



B8. How frequently, if at all, did you have to act in a way which conflicted with your values when at work during the pandemic? All HCPs (**1,683**) . *Please note this question refers to any point during the pandemic.*

^ significantly higher than the average of other groups
** significantly lower than the average of other groups*

Examples of acting in conflict with values

IFF Research

Harm from inability to escalate care

*It was **very difficult and upsetting to leave some sick patients at home** due to tightening of criteria for conveyance to A&E. Some of these patients would have deteriorated and died. I understand why it had to happen, but it went against my paramedic values.*

Paramedic

Care provided was not of usual quality

*We always escalated but it was uncomfortable as we **didn't have enough trained nurses** to deliver appropriate high quality critical care, and this was **never acknowledged** by the trust, health authority or Department of Health. This put a huge burden of moral injury on the staff who were often working beyond their comfort zone.*

Critical care doctor, North west

Pressure to make decisions

***GPs were told to do advance care planning and make rash decisions on DNACPR** especially on those that were most vulnerable, elderly and frail. This was totally unethical and we refused to do this.*

GP, London

Conflict between patient and staff safety

*One example of frontline staff being left to make very difficult decisions on managing critically unwell patients was **not being able to ventilate a patient, unless we were in level 3 PPE**… Ambulance staff were therefore forced to not intervene when they had the skills and equipment to hand and watch people die… Arguably this was implemented to protect ambulance staff from contracting COVID, but still an ethically challenging time.*

Paramedic

Preventing visits to patients

***Preventing families from visiting dying relatives** was completely inhuman, and forcing people to be apart from their loved ones at the moment of their death has haunted me every day since and will haunt me until the day I die. This was what went against my values on an hourly basis.*

Critical care doctor, Wales

B9. Anything else you would like to share with us about escalation of care decisions during the pandemic… All HCPs (**1,683**)

Conclusions

Conclusions (1/2)

This research shows **clear evidence that resource shortages affected escalation decisions** during the pandemic.

While resource barriers to escalation do exist at other times, there is also evidence that this problem became more acute during the pandemic with **more patients affected and those affected being more severely ill** than pre-pandemic.

Challenges with escalation were **more** commonly reported in **London and East of England,** suggesting particular pressure on capacity in these regions.

A **lack of available beds and staff** contributed to escalation challenges.

The key shortage preventing escalation was **lack of available beds**, followed by **lack of staff (overall or at the right level)**.

Insufficient staff was also seen as a **barrier to good quality patient care** during the pandemic by over two thirds of HCPs.

Care not being provided at the usual level (often due to a lack of staff) was one of the reasons that many staff felt they had **had to act in conflict with their values** during the pandemic, with distressing episodes being recalled in some of the comments given in this research.

Conclusions (2/2)

Support for HCPs could be improved, including through improvements to guidance and more acknowledgement of the challenging situation.

There was **room for improvement in terms of how supported HCPs felt** by many organisations, particularly national authorities and regulators, although employer support was better, with most HCPs feeling at least fairly well supported.

Those who had suggestions for additional support focused on the **clarity and consistency of guidance**, wanting fewer changes, and more local and national data available. They wanted the pandemic response and associated communications to **be based on evidence and to be quicker**. They also wanted **acknowledgement of the challenges** inherent in these decisions, rather than criticism, and better access to senior staff to support these decisions.

Overall, this suggests a need for better pandemic preparedness by ensuring healthcare systems are able to:

- **rapidly increase bed capacity of all types, including high dependency units, and augment staffing capacity**
- **disseminate clear, prompt, evidence-based and consistent guidance covering all healthcare services**
- **implement senior multidisciplinary team support that acknowledges the challenging nature of escalation decisions.**

Annex

111 clinical advisors

What additional support or guidance would have helped your confidence in making escalation of care decisions during the pandemic?

When making a decision based on clinical knowledge and expertise the company only criticised the actions taken.

111 clinical advisor

The policies changed so many times in just one shift, we could not keep up with them. It was embarrassing that patients were saying that's not what's on the Public Health England website.

111 clinical advisor

Having coherent guidance from PHE for everyone to work from, but this changed on a daily basis, with each hospital implementing it in different ways, which changed each day, with different procedures, which changed each day.

111 clinical advisor

111 clinical advisors

If there is anything else you would like to share with us about escalation of care decisions during the pandemic, please write this in the box below.

If positive Covid patients came to ask for advice, these were passed to other clinicians causing a delay in patient care as the other clinicians would also have lists of patients to deal with

111 clinical advisor

I felt that I was fighting a losing battle as there were many restrictions on where we as 111 staff could refer patients. Patients were frequently telling me of the difficulties they experienced in accessing their GPs. Patients were often just left without access to medical help.

111 clinical advisor

Callers would call 111, and we would provide current government guidance. In my view any new updates should have been implemented with immediate effect. We would follow this guidance, so I could be advising a caller at 8pm 'there is no need to isolate' knowing the guidance was to change at midnight to isolate.

The number of DNAR received from GP practices at the start of the first wave was heart breaking. We would receive this information from GP Surgeries, and this was updated in patients records. We were receiving a huge number of names from the same care homes. This was not usual practice.

111 clinical advisor

Glossary

A&E	Accident and emergency department.
CP	Core Participant: an organisation with a central role in a public inquiry, and that has certain rights, for example to make statements at any public hearings or to propose questions for the Counsel to the Inquiry to ask witnesses. For a list of Core Participants in Module 3 of the UK Covid Inquiry, please see https://www.covid19.public-inquiry.uk/documents/list-of-module-3-core-participants/ .
DNAR/DNACPR	A 'Do not attempt (cardiopulmonary) resuscitation' decision is recorded so that if a person has a cardiac arrest or dies suddenly, there will be guidance on what action should or shouldn't be taken by a healthcare professional, including not performing CPR on the person. It is a clinical decision, but the patient or their loved ones should always be involved wherever possible. It is often included as part of a more holistic "Treatment Escalation Plan".
Escalation of care	Moving a patient in need of more care to a more intensive category of treatment, including calling an ambulance or taking a patient to hospital, accepting patients onto a hospital ward from outpatient care, or transferring or admitting patients to critical care.
HDU	High Dependency Unit: a part of a hospital offering a higher level of treatment than a standard ward, but less intensive treatment than an intensive therapy unit (ITU/ICU)
HCP	Healthcare professional(s)
ICU/ITU	Intensive Care/Therapy Unit: a specialised hospital ward to provide treatment to seriously ill patients.
PPE	Personal Protective Equipment is intended to be worn by a person at work to protect them from risks to their health and safety. For infection prevention, PPE can include respirator masks, gloves, gowns and goggles.
Primary care	Care at the first point of contact within the healthcare system, to treat common illnesses or manage long-term conditions. This includes services such as GP practices and pharmacies.