What are we learning from COVID-19 crisis and how we see these lessons bearing fruit?

In the midst of an unprecedented health emergency, it may seem strange to speak of 'gains', i.e. gains from our experience in combatting COVID-19. The loss of loved ones through COVID-19 is a terrible tragedy and no 'gain' or advances in our approach can ever outweigh this loss. But in this context, we face an even greater responsibility to be clear on what we are learning from this crisis and how these lessons can benefit others in the future post-COVID world.

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From our perspective working within the Academic Health Science Network (AHSN) system, we are seeing advances in thinking and practice in several key areas for the future of the NHS, and the network is collecting lessons learned for future dissemination. We would like to suggest a few of these advances to be considered at this early stage as gains to hold, further gains to push for, based on the COVID experience, as well as changes in healthcare system dynamics that are required to fully grasp these gains.

'**Gains to hold**'

'Gains to hold' include both how healthcare is being practised in the midst of COVID-19, how we are introducing innovation into practice, greater flexibility in roles within the NHS and productive partnerships between the public, private and third sectors of the health economy.

Most obvious is the rapid and dramatic shift to remote medical consultations. Using online tools and simple phone calls, we have demonstrated that many primary care and specialist consultations can quite effectively be done remotely. For example, skin lesion images and heart irregularities can be transmitted to inform these sessions, and of course patients can report the outcomes of current treatments. The level of such remote consultations will undoubtedly fall to some extent after the crisis, but we will have seen a major breakthrough in their use and widespread adoption of the relevant supportive digital tools, and the AHSNs have been intimately involved in ensuring these tools are introduced. With this learning and with the benefit of a further period of time, there is the opportunity to refine utilisation and get the most out of newly familiar technology.

Until now, the received wisdom was that the NHS could not be expected to take up innovations rapidly, with 17 years being often quoted as the UK standard for the delay between first appearance and widespread use. Now we know that the system can adopt what it urgently needs in a matter of weeks, if not days. Until COVID struck, the Accelerated Access Review (in which one of us took part) and the Accelerated Access Collaborative that took forward its recommendations, has been focused on accelerating a very few transformative innovations. The role of the AAC in this crisis has widened the aperture significantly and we support the aperture remaining wide, and the speed remaining fast.

We have also seen redeployment of people and skills on a massive scale, across medical disciplines, between doctors, nurses, ancillary workers and pharmacists. We have learned that knowledge can be transmitted as fast as the virus, if not faster, and systems for democratising knowledge and data should emerge from our experience.

As AHSNs, we are also very focused on partnerships across the public, private and charity sectors of the health economy, and our boards are one of the few places in which all three come together around the same problem-solving table. The UK history has unfortunately too often been of mutual misunderstanding or suspicion across cultural divides. The COVID-19 crisis has broken these down dramatically, with just one example of a major pharmaceutical company approaching their local Academic Health Science Network to help plug the gap in viral testing. And, of course, many companies whose business is not health have pitched in, whether to manufacture masks or other PPE, or support their local communities. Let us work so that the partnerships forged in the crisis lay the foundation for a much more collaborative future.

These are all solid gains to hold, if we are determined to do so. In addition, we see the need to push for advances in three other areas of huge importance for the future of the NHS: how we prioritise prevention, how we assess value and how we share data.

Further gains to push for

Holding the gains requires us all to capture the learning, now, on how positive change has been delivered at pace and scale: the generous collaborations, the inspired communications, the changemaking, the focused strategy, etc. We then need to consider how to incorporate this behaviour into a calmer future environment.

Learning from the virus' impact on those who are frail and have underlying health conditions brings into fresh focus how the NHS thinks about its job and its performance. As was pointed out in a recent All-Party Parliamentary Group report, Health of the Nation, the NHS is still primarily an *illness* service. For the NHS to become more of a *health* service, it needs to value more highly its contribution to maintaining the public's long-term health and resilience via an increased investment in self-care and in supporting citizens with long-term conditions to manage and maintain independence for longer.

Despite fine words on focusing on the upstream, only about 5% of the NHS budget goes on prevention, which is pressurised out of hospital budgets by secondary care cost inflation. As a result, we have a rising tide of health-vulnerable people, particularly in the more deprived sectors of society. 'Underlying health conditions'—most of them avoidable—are clearly major factors in morbidity and mortality from the virus. They are of course major factors in healthy lifespan in general—virus or no virus. We need to keep this firmly in mind when shaping the plans and budgets of the new primary care networks and ICSs and in HM Treasury / DHSC negotiations, keeping in mind that most prevention measures do not have an in-year ROI.

Fast and wide data sharing is a major feature of the crisis, as specialists and hospitals try to analyse available data on an unfamiliar condition and generate information and insights leading to new approaches and novel therapies. The Health Data Research hub dedicated to critical care, PIONEER, will be in the forefront of this. This data and knowledge sharing within the NHS and across the world is itself a 'gain to hold'. We should see an even more significant advance in data sharing as citizens report symptoms or antibody status and/or potential contacts in the context of an 'exit strategy', a strategy that we are yet to see. Yet, such strategy is indispensible if we are to emerge from lockdown and not suffer successive future waves of infection. Looking beyond COVID-19, ready and responsible data sharing between individuals and the system—which of course needs to be two-way, for example through a smartphone app—is such an important tool that we need to overcome the reluctance of some stakeholders to support it. Good governance will be key, as will be the ability for people to see and control how their data is used. Good analysis of data to create knowledge and information for decision-taking will also be key.

Changing healthcare system dynamics

Finally, we believe this period is a wakeup call that should cause us to change some beliefs about our healthcare system and the behaviours of staff and citizens. Firstly the belief that that our health is the NHS' problem, not our own. Personal responsibility for maintaining strong health status and reducing health vulnerability will surely increase in the wake of COVID-19, and we should see a growth in demand from citizens and response from innovators for tools to enable this.

The second belief that will be questioned is that health workers—particularly domiciliary workers and health assistants—are doing low-level work that merits low pay. They have acted bravely and professionally on the front line and should surely now receive just reward. Thirdly, the belief that the NHS and private providers are enemies. In contrast, we have seen that agreements to work together and switch capacity reveal that they are on the same side in any health battle. Finally, there is a belief that the NHS is a supertanker that we can never expect to move fast. It can and it has done so. We must collectively learn from how this was achieved and how the NHS can continue to respond positively to population needs at a faster pace and scale.