

Analytical Collaboration for COVID-19

Summary Report

This report has been produced by the Strategy Unit on behalf of the Analytical Collaboration for COVID-19. A collaboration between the Health Foundation, Kings Fund, Nuffield Trust, and the Strategy Unit.

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1. Overview

The Analytical Collaboration for COVID-19 was established to provide analytical support to the health and care system to help in the fight against COVID-19. It was a collaboration between the Health Foundation, Kings Fund, Nuffield Trust, and the Strategy Unit¹

The purpose of the Collaboration was to coordinate efforts through the sharing of knowledge, information, multi-disciplinary analytical skills, and extensive links into different parts of the health and care system.

Over the first phase of the pandemic, the Collaboration worked on a set of projects (outlined below) which were developed and prioritised by the Collaboration partners, informed by discussions with key stakeholders. The questions typically were those which the NHS may have lacked the capacity to address at the time (e.g., because they were more medium-term 'recovery' focussed), or which cut across sectors, or which could benefit in particular from independent analysis.

The Collaboration also offered a rapid response service which involved producing short briefings on emerging questions. These included international comparisons of ICU Mortality and early COVID-19 deaths data.

Finally, the Strategy Unit team on behalf of the Collaboration produced regular evidence summaries and evidence trackers to keep up to date with the emerging evidence base on the following topics (which were prioritised by the NHSE/I CEO's Office):

- Effects on people in care homes, nursing homes and other residential facilities.
- Impacts of lifting restrictions.
- Rehabilitation needs and post-ICU recovery for severe COVID-19 patients.
- Implications of the broader impacts of COVID-19 for healthcare.
- Impact on health services of reducing non-Covid related activity/access.
- Screening and testing strategies.
- Emerging prospective whole population studies.
- Impacts on inequalities and marginalised groups.

All of these COVID-19 evidence summaries can be found here:

<https://www.strategyunitwm.nhs.uk/evidence-helping-you-keep-date>

This brief report summarises the work of the Analytical Collaboration for COVID-19 and draws together its various outputs. Section 2 provides a detailed description of our approach to the

¹ Note: Imperial College Health Partners agreed to join at the outset, but operational pressures meant that they were unable to participate in practice.

evidence summaries. Section 3 provides brief overview of the projects including links (where possible) to final outputs. Finally, Section 4 provides a few observations about the Collaboration and its legacy.

Question ²	Lead organisation
1. What is the impact of Covid-19 on healthcare in rural areas?	The Nuffield Trust
2. What can we learn from the wide range of different analytical approaches adopted to modelling of Covid 19 and how decision makers have reacted to that'	Collaboration project led by the Strategy Unit
3. What has been the impact of the shift to telehealth on number of appointments?	The Nuffield Trust
4. In what circumstances / for what presentations are remote (telephone / video) GP consultations proved to be particularly useful or problematic?	The Kings Fund
5. How might we capture the learning from practice innovations that have been developed out of necessity in response to the covid19 outbreak?	The Strategy Unit
6. How did utilisation of other healthcare services (GPs and A&E) by non-COVID patients change, and why?	The Health Foundation
7. What are the likely nature and scale of the impacts of the covid-19 pandemic on population mental health and wellbeing?	The Strategy Unit
8. What is the impact of COVID-19 on community services and might it change over time?	The Nuffield Trust
9. What will be the impact on waiting lists, and how do we bring people back (e.g., priorities and pace)?	The Strategy Unit
10. What can we understand from placing the modelled scenarios of excess deaths due to covid19 in an historical context for metrics such as death numbers, mortality rates, life expectancy, years of life lost etc?	The Strategy Unit
11. How might covid19 related mortality alter the population structure and patterns of unplanned healthcare utilisation in the medium term?	The Strategy Unit
12. What is the impact on the need for and use of social care for older people? (for example, arising from faster discharge from hospital, reduction in unpaid care because of social distancing)	The Health Foundation
13. How can learning from previous disasters inform England's response and recovery from Covid-19?	The Kings Fund

² The list of projects has evolved over the course of the pandemic, due to changing priorities some projects from previous iterations have not been taken forward.

2. COVID-19 Evidence alerts

The emerging evidence base for COVID-19 has grown rapidly since the start of 2020. Our knowledge of COVID in the early stages saw a reliance on research preprints and rapid analysis (not peer reviewed). The evidence base reflected the inherent volatility and ambiguity with an emergent epidemic, with significant gaps and uncertainties. The sheer volume and variable quality of research and analysis papers made it difficult for decision makers to keep track of new findings, thus risking patient harm, wasted resource and duplicated analysis.

The Collaboration recognised that a systematic and coordinated approach was needed to identify and share important new evidence to inform recovery planning. Whilst there were other initiatives to coordinate evidence reviews to inform the clinical and public health responses, we sensed that the commissioning perspective was an important gap.

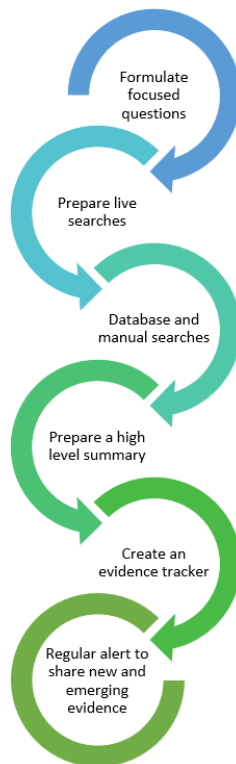
"more papers that include the term 'coronavirus' have been published in just the past six months than in the previous 70 years" (LoTiempo et al, 2020)³

"This wealth of new knowledge can be a curse: scientists and policymakers drown in the open sea of literature; unsure which papers are life rafts, and which are flotsam." (LoTiempo et al, 2020)

To address this, we set up a team of five evidence analysts to deliver an alert service to inform recovery planning from April to September 2020. A series of priority topics were identified in discussion with the NHSE/I CEO's Office, followed by a rapid review process to collate key papers, and summarise key findings for each topic. A regular alert was published to update decision makers with new and emerging evidence. For each topic, an evidence tracker was created, providing a catalogue of useful evidence. To ensure timeliness, our approach was pragmatic rather than exhaustive and search strategies focused on specificity rather than sensitivity. We recognised the importance of scanning a diversity of evidence sources to better inform our understanding of the impacts of COVID on health outcomes and on delivery of health care.

Search sources and locations		
Bibliographic databases: <ul style="list-style-type: none">• Pubmed• Google Scholar	<ul style="list-style-type: none">• Cochrane Library• CINAHL	<ul style="list-style-type: none">• LitCOVID• Disaster Lit
Aggregators and search engines: <ul style="list-style-type: none">• NHS Evidence• TRIP (using Covid filters)	Grey literature: searches of websites curated in our Covid-19 and Coronavirus collection https://wakelet.com/@Covid19Collaboration	

³ LoTiempo J et al, *We Can Do Better: Lessons Learned on Data Sharing in COVID-19 Pandemic Can Inform Future Outbreak Preparedness and Response*. Science and Diplomacy, 2020, <https://www.sciencediplomacy.org/article/2020/we-can-do-better-lessons-learned-data-sharing-in-covid-19-pandemic-can-inform-future>.



The emerging evidence base on Covid19 and Coronavirus is growing quickly. At the time of writing, a Google Scholar search for "COVID 19" results in 116,000 hits. By agreeing a well-defined scope and clear inclusion/ exclusion criteria, we can focus on papers which are highly relevant.

The team will prepare live searches on [Pubmed](#) and [Google Scholar](#). These will show as links which can be clicked on to run the relevant search, thus providing a quick and easy route to the broad published evidence base for each question.

The team will set up automated searches in licensed databases and search other key sources manually to identify research papers, evaluations and lessons learned reports.

There may be valuable lessons to be learned from research into and evaluations of responses to previous pandemics/ major incidents, which could provide a useful balance to the plethora of (unreviewed) studies emerging from the current crisis.

From these initial searches, we will prepare a short high-level summary of the key findings.
Please note that due to timescales, it will not be possible to conduct full critical appraisals of papers.

The evidence map model is a useful way of tracking evidence which is rapidly growing/changing*.
The map will be a live resource, updated regularly

We will re-run searches on a weekly basis, to identify new and emerging evidence from ongoing research and analysis, which will be shared via a weekly alert.
The evidence map will be updated to provide an accessible index to the evidence on each question.

* For example, <http://epi.ioe.ac.uk/cms/Projects/DepartmentofHealthandSocialCare/Publishedreviews/COVID-19Livingssystematicmapoftheevidence/tabid/3765/Default.aspx>

The summaries, trackers and alerts can be found at <https://www.strategyunitwm.nhs.uk/evidence-helping-you-keep-date>. These include:

- Effects on people in care homes, nursing homes and other residential facilities
- Impacts of lifting lockdown and other restrictions.
- Rehabilitation needs and post-ICU recovery for COVID-19 patients.
- Implications of the broader impacts of COVID-19 for healthcare
- Impact on health services of reducing non-COVID related activity/access.
- Screening and testing strategies.

We also prepared a short summary on emerging prospective whole population studies and an evidence map on the impacts of COVID on inequalities and marginalised groups.

The final three evidence alerts included our brief reflections on the evidence we scanned over the course of this project. The alerting service was appreciated by decision makers, who often fed back on the value of a regular alert, signposting key papers for priority topics. Our experience suggests that whilst this service was resource-intensive, the state of the evidence base at the time warranted an intensive approach. As time has progressed, priorities have changed and future work is likely to be more focused in terms of the questions of interest and sources to be scanned (for example, we are likely to be less reliant on preprints and commentaries). We therefore stopped the scanning service in October 2020.

3. The Projects

These projects were identified and developed by Collaboration partners in discussion with key stakeholders. The contribution from the three think tanks was self-funded; the work of the Strategy Unit (on projects but also in coordinating the Collaboration) was resourced with the support of national COVID-19 funds transacted through Midlands and Lancashire CSU (the Strategy Unit’s host organisation).

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12. What is the impact on the need for and use of social care for older people? (for example, arising from faster discharge from hospital, reduction in unpaid care because of social distancing)	The Health Foundation
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The way in which these questions were addressed varied significantly depending on the context. In some instances, the work led to a blog or short report where speed of getting an issue aired was key; in other instances, addressing the question required substantial de novo analysis and modelling work to be undertaken.

Where possible the links to final outputs are shared below. Some reports were produced for specific stakeholders and are therefore not currently in the public domain.

3.1 What is the impact of Covid-19 on healthcare in rural areas?

This analysis explored the impact the pandemic has had on the delivery of rural and remote health services in England, highlighting the underlying challenges faced by these services – and outlines how the challenges faced are different for rural areas in comparison with more urban areas. It also discusses how performance could be monitored to signal the risk of any significant service pressures over the coming months.

Read the analysis here: [Rural, remote and at risk](#) (published 11th December 2020)

3.2 What can we learn from the wide range of different analytical approaches adopted to modelling of Covid 19 and how decision makers have reacted to that?

The aim of this project was to learn from the use of evidence derived from quantitative methods during the covid-19 pandemic by the NHS and social care system. To do this we focused on the following questions:

1. What were the key decisions made by the NHS and social care systems in which evidence from quantitative models played a part? What were the decisions made which should have but did not use evidence from quantitative models?
2. What types of quantitative models were developed in response to these decisions and how were they used? Where models were not used, why was this?
3. From the viewpoint of decision makers in the NHS and social care system, what were the main challenges they faced in using evidence from quantitative models during the pandemic? What worked well and where was there room for improvement?
4. From the viewpoint of analysts, what were the main challenges in producing evidence using these models? What worked well and where was there room for improvement?
5. To prepare for future crises like this, what should be done to create a more resilient future system for providing decision makers with high quality evidence from quantitative models?

This project is still on-going. Semi-structured interviews have been conducted with a wide range of participants, ranging across national analytical and incident leads, regional commanders (for the COVID emergency response), system level leaders and analysts, local government partners and analysts and operational leads in individual organisations. Initial findings have been developed across the three teams supporting the project (Strategy Unit; Health Foundation; Nuffield Trust) and were tested further in a workshop for an invited audience held as part of the Strategy Unit's INSIGHT2020 Festival in late October. It is anticipated that a final discussion document will be published in March 2021.

3.3 What has been the impact of the shift to telehealth on number of appointments?

The pandemic has brought around huge changes in general practice. This project sought to understand what has changed during lockdown, and what it might mean for the future of primary care.

See the blog here: [How has lockdown affected general practice and where do we go from here](#) (published 8th July 2020)

3.4 In what circumstances / for what presentations have remote (telephone / video) GP consultations proved to be particularly useful or problematic?

This project sought to explore:

1. What service change has happened and what digital products and services were used?
2. What factors enabled these service changes?
3. Can they be sustained outside of the pandemic response?
4. What should be considered in moving to the next phase of pandemic response and post-recovery future? i.e., what changes that should be kept or extended/stopped/amended and which might need/be amenable to policy interventions to achieve that.

An initial report has been submitted to the Department of Health and Social Care with further work to be planned. These reports are not currently in the public domain.

3.5 How might we capture the learning from practice innovations that have been developed out of necessity in response to the covid19 outbreak?

During the COVID-19 pandemic we have seen rapid changes in ways of working. We have seen an increase in collaboration, particularly through digital platforms, the sharing of data, and people describing 'true system working'.

So how do we capture innovations and changes in practice? How do we learn from them? How do we identify what should be continued and what should not? How do we sort promising, effective changes from those that are ineffective – or even potentially harmful?

If we do not think about how to do this systematically there is a risk that learning will be lost as pressures to 'return to normal' increase.

[COVID-19 Learning Guide](#) (published September 2020)

This guide has been developed to help health and social care teams and their leaders learn from service changes put in place or accelerated during the COVID-19 response. The guide is not exhaustive. It offers an overview and practical, helpful suggestions of how learning can be captured and acted upon. It signposts to more detailed resources.

3.6 How did utilisation of other healthcare services (GPs and A&E) by non-COVID patients change, and why?

This project looked at the following questions:

- How does use of NHS and social care services during the COVID-affected period compare to use usually?
- What are the changes in health and care needs over the COVID-affected period? (there will be increased needs for some people (e.g., mental health) and reduced needs (road traffic accidents))
- How much of the difference between observed and usual service use cannot be explained by changes in needs?
- What are the factors causing this e.g., service availability, propensity to seek care?
- What are the implications of this for health needs and "pent up" demand?

These were answered through a series of blogs published by the Health Foundation:

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- [Use of primary care during the COVID-19 pandemic](#) (17th September 2020)
 - [How has children and young people's usage of A&E been impacted by lockdown and social distancing?](#) (3rd September 2020)
 - [Exploring the fall in A&E visits during the pandemic](#) (30th June 2020)
 - [How is COVID-19 changing the use of emergency care by region?](#) (3rd June 2020)

In addition, much of the underpinning analytical work on ED attendances has been published in Lancet Regional Europe in a paper produced by Collaboration members Wyatt et al. (2021)⁴.

3.7 What are the likely nature and scale of the impacts of the COVID-19 pandemic on population mental health and wellbeing?

Early in the Covid pandemic, it became clear that people's mental health would suffer. Whether through bereavement, unemployment, social isolation, not being able to access support services – or a host of other routes – an alarming picture began to emerge and attract attention.

The detail of this picture has become progressively clearer. Press reports, population surveys, stories from service users and staff; evidence has emerged and accumulated. We are gaining an increasingly refined understanding of exactly how bad the pandemic has been for the nation's mental health.

Against this background the Strategy Unit, working initially with colleagues at Mersey Care NHS Foundation Trust as an exemplar, has produced a model to help local services plan their response: [Mental Health Surge Model](#) (published November 2020). This System Dynamics model was developed in open-source code so it could be replicated across the NHS.

The model and associated resources were launched on 11th November and sent to national and regional leads for mental health, the Royal College of Psychiatrists as well as extensive circulation and promotion via social media, informal mental health networks and the [Health Services Journal](#). The results also informed the [Health Foundation response](#) to the Spending Review. Additionally, a national walk-through huddle for the interactive tool was delivered to 80 NHS analysts after launch and an International Seminar was delivered to academic and strategic leaders on behalf of the Judge Business School at the University of Cambridge.

⁴ [https://www.thelancet.com/journals/lanep/article/PIIS2666-7762\(21\)00011-9/fulltext](https://www.thelancet.com/journals/lanep/article/PIIS2666-7762(21)00011-9/fulltext)

Since launching the model, we have supported several areas or systems (Birmingham & Solihull, Thurrock, PHE South East, South West Yorkshire, West London, North East London, Bradford) to populate and adapt the model for their local circumstance. Other agencies (HEE East of England, BEAT charity, NHSE South) have expressed an interest in developing the models for workforce planning purposes and exploring more detailed pathways around psychosis and eating disorders. Several have used the outputs to support bids for additional non-recurrent funding.

We see this work as a helpful start, not the final word, and will continue to share approaches and ideas with other modellers in this area via the [Mental Health System Improvement Network](#).

3.8 What is the impact of COVID-19 on community services and might it change over time?

The Nuffield Trust are exploring the impact of COVID-19 on community services. This project aims to understand the impact of COVID-19 on community services use and consider how this might change over time.

The analysis has focussed on two cohorts of patients in particular. First, patients who were discharged from hospital in March and April 2020 to free up beds as the NHS prepared for Covid-19 admissions. And second, patients who were treated in hospital for Covid-19, many of whom have rehabilitation needs and ongoing health problems.

The first output from the project focused on hospital discharges at the start of the pandemic, where patients ended up, and what the implications of policy decisions to free up hospital beds might mean moving forward: [How did the NHS free up hospital capacity at the start of the pandemic?](#) (published 6th August 2020)

Further information on the project can be found here:

<https://www.nuffieldtrust.org.uk/project/impact-of-covid-19-on-community-services>

(published 4th January 2021)

3.9 What will be the impact on waiting lists, and how do we bring people back (e.g., priorities and pace)?

The Strategy Unit has produced a model to support local systems working through the dynamics of elective recovery.

The brief was to build a usable model that could be adopted and adapted locally, and that allowed the running of multiple scenarios to help inform local planning. A System Dynamics modelling approach was used to deliver this. The model was developed and tested with the NHSE/I Midlands Region. It is based around the resources required to deliver waiting list activity. It was presented to

several regional and national groups at different points of its development. This helped shape the approach to modelling and how the outputs were presented.

The model has been released for local systems to test their own assumptions. This included releasing the script that created the input data and full data specifications. This allows local systems to populate the models and see how a set of pre-developed assumptions impact on their waiting list performance. They are also able to develop their own scenarios using a free version of the development software. Some local datasets were also created for a small number of analysts to help them use the model to validate their own models.

The Model has since been used to model the cost of different recovery scenarios for the Health Foundation's response to the Comprehensive Spending Review.

The model is freely available for non-commercial use. Instructions on accessing the model and working with it are available here:

[Modelling the impact of Covid on waiting lists for planned care](#) (published July 2020)

Starting in November 2020, a further project is underway (Strategy Unit and IPSOS MORI), commissioned by NHSE&I, to try to better understand the way that COVID-19 has impacted on choices made about referral and treatment for patients, referrers, and treaters. One output of this project (eta March 2021) will be revised input parameters for the model described above.

3.10 What can we understand from placing the modelled scenarios of excess deaths due to covid19 in an historical context for metrics such as death numbers, mortality rates, life expectancy, years of life lost etc?

This project sought to answer the following questions:

- What are the various sources of covid19 related mortality estimates and forecasts; how do these compare numerically and methodologically?
- What is the relationship between deaths caused by covid19, deaths of patients with (or suspected to have) the covid19 virus and excess mortality during the outbreak period?
- To what extent might the covid19 outbreak have shortened people's lives?
- How might covid19-related mortality impact on a range of mortality related metrics (age standardised mortality rates, life expectancy, potential years of life lost)?
- How do these figures compare to historical rates?

The final report is due to be published Spring 2021.

3.11 How might covid19 related mortality alter the population structure and patterns of unplanned healthcare utilisation in the medium term?

How might the Covid-19 outbreak influence rates of unplanned hospital use in 2021, 2022 and 2023, given that:

- unplanned hospital use tends to rise sharply as patients approach the end of life (c. 40% of emergency beds are occupied by patients in the last 2 years of life)
- in England, tens of thousands of people are expected to die as a direct or indirect result of the covid19 outbreak and many of these would otherwise have died in the next few years
- a substantial number of covid19 patients will survive a period in intensive care but may require aftercare, rehabilitation, or long-term health management

This report is due to be published Spring 2021.

3.12 What is the impact on the need for and use of social care for older people? (for example, arising from faster discharge from hospital, reduction in unpaid care because of social distancing)

Looking at this question near the start of the pandemic the Health Foundation blog [What has been the impact of COVID-19 on care homes and the social care workforce?](#) (published 15th May 2020) and report on [Adult social care and COVID-19: Assessing the impact on social care users and staff in England so far \(published July 2020\)](#) highlight some of the significant challenges faced by the care system.

- Office for National Statistics (ONS) data released 12th May 2020 highlight significant weaknesses in the social care system. High death rates sustained during the COVID-19 pandemic demonstrate the stark impact of the virus on care home residents and social care workers.
- While deaths in hospitals have declined from a peak in the week ending 17 April, COVID-19 has continued to spread in care homes. In the week ending 1 May, the number of deaths in

care homes from all causes (6,409) exceeded the number of deaths in hospital (6,397) for the first time since the start of the outbreak.

- The outbreak is also having a devastating impact on people working in social care. When adjusted for age and sex, social care workers have twice the rate of death due to COVID-19 compared to the general population.
- Between 10 April and 8 May, 3,161 people receiving domiciliary care in the community died. This is over twice the number expected (1,171 deaths) at this time of year.
- Action to tackle the coronavirus pandemic in social care has been late and inadequate. The government has announced a package of £600m available for infection control in care homes. It is vital that this reaches front line providers and that the huge practical challenges of personal and protective equipment (PPE) and testing logistics are resolved.
- During March and April, there was a substantial reduction in hospital admissions among care home residents. This may have reduced the risk of transmission but there may have also been an increase in unmet health needs.

In addition, regional variation in the impact on care homes was highlighted in a blog [Do all care home residents face an equal risk of dying from COVID-19?](#) Further work is underway to understand the clinical characteristics and care needs of people admitted to hospital from care homes during the pandemic, this is due to be published later in February.

3.13 How can learning from previous disasters inform England's response and recovery from Covid-19?

This project focused on drawing together learning, both from formal reviews and lived experience, of previous cases of 'stepping down' from crisis mode in health and care services. The purpose was to identify priority areas to focus on to support greater community health resilience and recovery from crisis. These included: support for the workforce to support recovery and avoid burnout; the need for psychosocial support through formal and informal networks; the importance of multi-agency working and community engagement; and a focus on meeting the needs of groups at risk of being left behind in recovery efforts.

The final report can be found here: [Covid-19 recovery and resilience: what can health and care learn from other disasters?](#) (published 4th February 2021)

4. The Collaboration and its legacy

Reflections from Peter Spilsbury, Director of the Strategy Unit

The Analytical Collaboration for COVID-19 was set up rapidly in response to a suggestion made by NHSE&I nationally. Whilst there are always regular interactions between the think tanks, this attempt to coordinate work was a new departure. What was also new was the decision at the outset to draw into this collaboration the Strategy Unit, a specialist NHS analytical, evaluation and strategy development team. Again, whilst the Strategy Unit had worked with some of the think tanks on previous projects, the decision to embrace it fully in the Collaboration was a significant development, one that recognised the Strategy Unit's perhaps unique position as an NHS team able to work effectively at the research/policy/practice interface.

Because the independence of the think tanks is an important part of the fabric of UK NHS policy making and service development, it was important to find a way of balancing the ability of the think tanks to set their own agenda, with the obvious case for avoiding duplication, and for addressing topics identified as priorities by national policy leads. This was managed by:

1. Seeking widespread input across the national leaders of the NHS, arms-length bodies, and Government on the most important questions of the moment and combining that with collated lists developed internally by the Collaboration partners.
2. An early systematic review of these questions in terms of a) the capability/capacity of the Collaboration partners to address them; and b) whether work was already underway elsewhere in the research community, in order to produce a prioritised list.
3. Projects allocated, consensually, to Collaboration members in accordance with prior interests/preferences/capacity.
4. Work on the projects was undertaken, in almost all cases, by an individual organisation's team, drawing on the Collaboration as required for extra data/intelligence; interpretation; linkages across projects (rather than trying to form joint teams)
5. Individual members continued with other COVID work out with the Collaboration agreed work programme, in line with their own priorities/context, but this was shared across members to avoid overlap.

The approach to managing the Collaboration was essentially informal (though with a documented approach). The Collaboration coordination team⁵ met weekly and maintained very regular communications with NHSE/I nationally to ensure that work underway remained relevant. The wider working group⁶ then met fortnightly to review progress.

⁵ Peter Spilsbury (SU) and Charles Tallack (HF) – Joint Chairs. Lucy Hawkins (SU); Alison Turner (SU); Holly Krelle (HF)- Secretariat

⁶ Peter Spilsbury (SU); Charles Tallack (HF); Sarah Deeny (HF: until September 2020); Mai Stafford (HF; from September 2020); Sarah Scobie (NT); Siva Anandaciva (KF)

Whilst the Analytical Collaboration for COVID-19 as such has now ended (with the agreed work programme completed), there is a clear legacy in terms of the enhanced level of joint work taking place between the various analytical teams. There are several significant projects now underway between various combinations of the collaboration partners which would likely not have transpired were it not for the strength of working relationships that were forged through the Collaboration.

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