

ORIGINAL ARTICLE

Optimising health system capacity: A case study of community care staff's role transition in response to the coronavirus pandemic

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Abstract

The coronavirus disease (COVID-19) increased the demand for critical care spaces and the task for individual countries was to optimise the capacity of their health systems. Correlating governance and health system capacity to respond to global crises has subsequently garnered the pace in reviewing normalised forms of identifying health priorities. Aligning global health security and universal health security enhances the capacity and resilience of a health system. However, weak methods of governance hinder the alignment necessary for controlling infection spread and coping with the increase in demand for hospital critical care. A range of qualitative studies has explored staff experiences of providing care in hospitals amidst the COVID-19 pandemic. Nonetheless, limited understanding of the influence of governance on health and social care staff experiences in response to the COVID-19 pandemic exists. This case study aimed to explore the influence of health system governance on community care staff experiences of role transition in response to the COVID-19 pandemic in England. We used criterion sampling to include community care staff initially recruited to deliver a community integrated model of dementia care at two facilities repurposed in March 2020 to optimise hospital critical care space. Six community care staff participated in the narrative correspondence inquiry. A lack of control over resources, limitations in collective action in decision making and lack of a voice underpinned staff experiences of role transition in contexts of current crisis preparedness, transition shock and moral dilemmas. Health system governance influenced the disposition of community care staff's role transition in response to the COVID-19 pandemic. Staff's mere coping clouds the glass of wider issues in health system governance and capacity. The normative dominance that the control over resources and centrally determined health system priorities ordain require reviewing to enable optimal health and social care cross systems' capacity and resilience.

KEYWORDS

case study, coronavirus response, healthcare capacity, role transition, system governance

1 | INTRODUCTION

The coronavirus disease (COVID-19) increased the demand for critical care spaces and the task for individual countries was to optimise the capacity of their health systems (Bayraktar et al., 2020). The Organisation for Economic Co-operation and Development (OECD) consortium's "S" priorities for optimal health system capacity in response to COVID-19 included space, staff and supplies (OECD, 2020). Correlating governance and health system capacity and resilience has subsequently garnered the pace for reviewing normalised forms of identifying health system priorities (Meessen, 2020). Lal et al. (2020) examined the influence of aligning global health security (GHS) with universal health security (UHS) on managing the COVID-19 pandemic and found that weak systems of governance hindered the effective response to the pandemic. GHS policy concerns protecting the global population from the risk of infectious diseases, whereas UHS focuses on accessible health services at no cost to the end-user (Wenham et al., 2019).

Health systems worldwide vary by country, and even where similarities exist, system governance and modes of service delivery differ. For example, Canadian and British health systems both focus on universal access to basic medical services for their residents (Martin et al., 2018). However, Canada's national response to COVID-19 was built on the collaborative culture across provinces established during the SARS outbreak (Webster, 2020). The United Kingdom (UK)'s centralised health system on the other hand retained the test, track and trace responsibilities for containing infection spread while responsive accountability was expected at a local level (Propper & Phillips, 2020). Germany experienced a surge in COVID-19 cases like the UK at the onset of the pandemic. Nonetheless, regional systems of directing and coordinating healthcare optimised Germany's capacity to adapt to the changing landscape in health and social care (Kirchhof, 2020). The United States of America and the UK rank high on the GHS index but both countries struggled with containing infection spread and registered a high number of COVID-19 fatalities (Lal et al., 2020). The UK richly invests in GHS and UHS, but the slow response and overall system governance angled the alignment that was necessary at the onset of the pandemic (Lal et al., 2020). Propper and Phillips (2020) identified a disparity between expectations and the actual local response in a highly centralised National Health Service (NHS). Centralisation in this case orientates a commanding culture, robbing lower cadres of the power to implement locally informed decisions (Kirchhof, 2020).

Although shortfalls in strategies for securing sufficient supplies have been cited (Propper & Phillips, 2020), the UK adopted a quick hospital discharge approach to boost the hospital capacity for critical care spaces (NHS England & NHS Improvement, 2020). This constituted a 'discharge to assess model' involving continued assessment of patient care needs at home or in a care home (Oliver, 2020). Community-based facilities for enabling smooth hospital patient flow were mapped urgently, but the support required did not follow suit (Dauncey et al., 2021). A range of qualitative studies documented exacting experiences of psychological distress among the

What is known about the topic?

- Joining new teams in an unfamiliar role was a common experience for health and social care staff in various care contexts.
- Changes in the work role and or environment involve a transition experience.

What this paper adds?

- System governance influences community staff experiences of role transition in response to a crisis.
- Successful community care role transition is contingent on the collective belief in individual and organisational capacities to implement change.

healthcare workforce in hospital care settings during the COVID-19 pandemic (Al Thobaity & Alshammari, 2020; Ardebili et al., 2020; Liu et al., 2020; Vindrola-Padros et al., 2020). Nonetheless, limited understanding of the influence of governance on health and social care staff experiences in response to the COVID-19 pandemic exists. More so, barely any literature exists exploring community care staff experiences of supporting strategies for optimising health system capacity in response to the COVID-19 pandemic. Yi et al. (2020) investigated usual community nursing service restructure to enable ongoing monitoring of long term conditions and health promotion campaigns during the pandemic. Our study aimed to explore the influence of health system governance on community care staff experiences of role transition in response to the COVID-19 pandemic in England.

2 | METHODS

2.1 | Context

Two newly established facilities originally earmarked to deliver a community integrated model of dementia care in the South of England were repurposed in March 2020. The goal was to enable patient flow and optimise hospital space for critical care under the discharge to assess (D2A) model in response to COVID-19. The intent for the D2A model was to rapidly discharge 95% of people from the hospital whereby detailed functional assessment and ongoing care occurred in a community care setting (NHS England & NHS Improvement, 2020). The facilities repurposed were originally built to promote and support the independence of people living with dementia for as long as possible, meeting their care needs in the community at every stage of condition progression. One facility was fully staffed and just about functional before the COVID-19 outbreak, whereas the opening of the second facility awaited operational technology for optimising residents' safety, recruitment of key staff and staff induction processes. Staff recruited were redeployed

within the repurposed facilities. Both sites certified for 'nursing home' type of care were affiliated to NHS community services. All patients cared for under the D2A model at the repurposed facilities were older adults.

2.2 | Study design

A single exploratory case design (Yin, 2003) was chosen to investigate community care staff's role transition in supporting the D2A model during the COVID-19 pandemic. The single case design was appropriate to reflect the unique circumstances of staff redeployed to support an unanticipated model of care in the community. Against the backdrop of health system governance, the predetermined proposition for the study was that system governance influenced the disposition of community care staff's role transition. System governance entails making sure that existent policy frameworks are integrated with effective oversight, coalition building, regulation and attention to system design and accountability (Bigdeli et al., 2020). Role transition on the other hand involves the psychological and, where applicable, physical movement to disengage from one role to engage in another role (Ashforth et al., 2011). Yin (2003) contends that study propositions guide the study through questions of 'why' and 'how' in examining phenomena in the real world particularly with latent boundaries between phenomenon and context. The case study was influenced by critical realism (Bhaskar & Danermark, 2006; Gorski, 2013) to identify mechanisms that underpinned the role transition of community care staff initially recruited to deliver a model of dementia care. Critical realism posits that concealed structures underlie observable events (Gorski, 2013). The theoretical approach we opted for embraces different levels of reality including participants' and researchers' when clarifying the 'how' and 'why' of events that manifest (Bhaskar & Danermark, 2006). The assumption that causal mechanisms are embedded within events experienced and that these events require exploration to exhume the causal mechanisms guides the critical realist perspective (Fletcher, 2017). The critical realist perspective was useful to examine the influence of health system governance on community care staff's role transition from delivering community dementia care to supporting the D2A in response to the COVID-19 pandemic.

2.3 | Recruitment

We used criterion purposive sampling with a view that the NHS formed partnerships with wider community services such as social care and housing but none of them had been specifically repurposed to boost the capacity for critical care space in hospitals. Criterion sampling minimises variation and includes only those participants that meet a predetermined criterion (Palinkas et al., 2015). Study participants were staff originally recruited to deliver a community-integrated model of dementia care. The call for narratives comprised an electronic flyer with the lead researcher's contact details for

potential participants to express interest and or obtain more information about the study. Two researchers conducted the study, one of whom is a research fellow and the second one a professor in community psychology and public mental health. Both researchers have substantial experience in conducting qualitative studies. Managers of the initially dementia care facilities who were known to the researchers distributed the 'call for narratives' flyer to their initial teams. Participants were unknown to the researchers before the study. Details in the information sheet required volunteering participants to provide written consent plus a direct telephone number before receiving narrative prompts to guide focus when documenting their tales of events. Eight out of potentially 20 staff from two community care facilities expressed interest to participate in the study, and only six community care staff completed the study.

2.4 | Ethics clearance

East of England-Essex Research Ethics Committee granted the study a positive ethical opinion. The study obtained ethics approval from the Health Research Authority and Health and Care Research Wales Ref: 19/EE/0314. We used the consolidated criteria for reporting qualitative research (Tong et al., 2007) to improve the clarity of reporting the study procedures.

2.5 | Data collection

A narrative correspondence method was an opportune strategy for collecting in-depth data amidst a pandemic (Grinyer & Thomas, 2001). The narrative correspondence inquiry is a data collection method where participants use prompts to recount events in the absence of a researcher (Grinyer, 2004; Milligan, 2005). Narratives are tales of individual views of the world offering deep insights into the context in which complex events occur (Riley & Hawe, 2005). The narrative correspondence inquiry empowered participants with control of the research process (Grinyer, 2004) to document their experiences in their own time. We tested the narrative prompts for clarity and consistency with staff providing dementia care in a residential community care setting, who also faced numerous changes in response to the COVID-19 pandemic. Narrative prompts asked about the participant's previous role; key changes to the model of care delivery; plus, anything else participant wished to recount about their current role. Participants had the choice to either audio record or write their accounts between July and October 2020. Sharing of information sheets, obtaining participant consent, and data transfer were all accomplished via email correspondence. The email correspondence method was an open opportunity for contacting individual participants about questions or gaps arising from the narrative data. All participants transferred the narrative data to the lead researcher in the form of typed Microsoft Word documents. The lead researcher contacted participants individually to gain access to the electronic password protected files. The narratives differed in length ranging

from 600 to 1,350 words, mounting to a total count of 5020 words across the six narratives we received. Participants' stories were richly comprehensive to deepen researchers' understanding of staff's experiences of role transition in supporting the D2A model in England. All participants captured their narratives as a one off despite the scope of up to 2 months to flexibly document their experiences. Although we received two of the narratives within 2 weeks of issuing the flyer inviting participants, the rest of the narratives were submitted within the last 2 weeks of the deadline following a reminder email. Each participant's 2 months deadline to document their experiences was based on the date they consented to take part in the study. In addition to capturing in-depth information on sensitive subjects and saving scarce resources, scientific rigour for the electronic research approach was enhanced by the predetermined methods (Hlatshwako et al., 2021).

2.6 | Analysis of narratives

We started analysing the data after receiving all six narratives. We employed the paradigmatic mode for analysing participants' accounts instead of narrative analysis. Narrative analysis concerns finding narrative meaning in qualitative undertones, whereas analysis of narratives focuses on organising data into categories to identify frequently appearing elements using a paradigm of choice to organise data (Kim, 2016). Critical realism posits three levels of reality including the empirical level where events are experienced; the actual level where events occur irrespective of whether they are observed and the real level at which mechanisms cause events to happen (Fletcher, 2017). Using community care staff's role transition as the unit of analysis, the first level of analysis involved distinguishing frequently mentioned experiences and developing short phrases to describe these. We considered data saturation at the individual participant level to enable researchers' full understanding of each participant's views (Saunders et al., 2018). We asked two of the participants who omitted the details of the patients they cared for to clarify the age group of people discharged from hospital to the repurposed facilities for community care. Secondly, we identified the context and conditions in which community staff experiences of supporting the D2A occurred. We drew on the theory of organisational readiness (Weiner, 2020) to distinguish the contexts in which participants reported experiences within identified conditions. Each context highlighted the level at which factors influenced the community care staff's role transition as illustrated in Table 1. The emphasis of the organisation was on the unique case of the community facilities repurposed to optimise critical care space in hospitals. Although the facilities formed subunits of the NHS whole system, the variation of function required an evaluation of both structural and psychological readiness for the change. Weiner (2020)'s theory of organisational readiness for change complemented the study's unit of analysis in examining organisational members' confidence in the collective capacity to implement the change. Based on the short phrases describing empirical events, we generated deductive constructs to illustrate the disposition of

role transition in each identified context. With the assumption that structural and individual agency carries varying degrees of power (Fletcher, 2017), we focused on identifying power relations influencing community care staffs' role transition in response to COVID-19 at the third level of analysis. Weiner (2020) distinguished collective behaviour in making changes in staffing, effective communication and participation in decision making as key aspects for leading successful implementation of organisational change. However, health systems are open systems depicting the hierarchical temperament of the NHS with interrelated subunits interacting dynamically, adapting to feedback from subunits and the overall environment (Meyer & O'Brien-Pallas, 2010). Structural and institutional rules mould individual behaviour, whereas the hierarchical structure of organisations shapes individual role identity and expectations (Dowding, 2008). We, therefore, examined the relationships between and within elements of the health systems governance framework including policymakers, people and providers (Bigdeli et al., 2020) to explain the power relations influencing the disposition of staff's role transition. We shared a summary of the findings with each of the participants to verify that the explanatory approach to the narratives was an accurate representation of their experiences. Participants individually agreed that results mirrored experiences recounted in their respective stories. We have used some excerpts from the data to enhance the credence of our findings.

3 | FINDINGS

The study sample constituted both male and female participants. Three out of the total six participants were regulated healthcare practitioners with experience in clinical care. The other three participants were unregulated care workers with experience of providing care for older people in differing settings. We identified three power relations that shaped the experiences of community staff's role transition across organisational, individual staff and service user contexts including the lack of:

- control over resources,
- collective action in decision making and
- a voice.

The presentation of findings corresponds to the constructs summarising the actualised disposition of community care staff's role transition comprising present crisis preparedness, transition shock and moral dilemmas. The power dynamics identified feature prominently across the various contexts of the community care staff's role transition.

3.1 | Present crisis preparedness

The requirement to urgently repurpose community-based dementia care facilities for patient care was an executive decision taken

TABLE 1 Levels of data analysis

Condition Level 2 inductive	Empirical events Level 1 inductive	Context Level 2 deductive	Disposition of role transition Level 2 deductive	Causal mechanisms Level 3 deductive
Repurpose community care facilities	<ul style="list-style-type: none"> • Poorly equipped for acute-intermediate care • Skills gaps in teams • Inappropriate referrals • Staff shortages • Inflexible (procurement) processes • Staff exits 	CHANGE EFFICACY Organisational context	Present crisis preparedness	POLICYMAKERS Lack of control over resources Centralised control but devolved accountability
Redeploy community dementia care staff to other roles	<ul style="list-style-type: none"> • Lack of role clarity • Perceived poor fit for the new role • Job dissatisfaction • Work overload • Fear of cross infections • Perceived lack of support • Long shift patterns • Perceived stagnation in role • Stress and anxiety 	CHANGE COMMITMENT Individual context	Transition shock	PROVIDERS Limited choices Lack of collective action in decision making
Protocols and controls	<ul style="list-style-type: none"> • Lack of patient stimulation • 24/7 monitoring • No consent to discharge destination • inadequate person-centredness in palliative care • Bounced around systems of care 	IMPLEMENTATION EFFECTIVENESS Service user context	Moral dilemmas	PEOPLE/ PUBLIC Lack of a voice

Note: Change efficacy, Change commitment, implementation effectiveness – Weiner (2020). Theory of organisational readiness for change. Policymakers, providers, people – Bigdeli et al. (2020). Health systems governance framework.

devoid of assessing the design and capacity of the facilities. The facilities were uniquely designed to promote the independence of people living with dementia with the help of artificial intelligence (AI) systems, which were not functional at the time of opening. Participants reported feelings of trepidation when gates to the facilities opened for the first time to patient transport and the limited capacity to handle the high level of patient acuity suddenly became apparent. Participants recounted:

The decision to open was made by 'Gold Command', a group of senior decision makers within the trust, many of whom had not been involved with the development or understanding of the environment/core principles. The unique set up, the reliance upon AI that wasn't in place and the new staff team made this an unnerving time

[Participant 1]

I feel there was a lack of insight from staff working in the same organisation about the people we could safely support in this unique environment. Unlike a ward where you can support a bay of patients by 'tag nursing' or cohort nursing, we have individual rooms

[Participant 2].

Participants expressed a general lack of policy awareness and skills gaps across teams, even within circumstances of limited

understanding of each other's core clinical capability. The deficit in registered nurses at the sites required staff to work extended hours to support the service. Obtaining the right equipment to care for individual patients was extremely difficult whereby processes in the organisation seemed convoluted and inflexible. Accepting and pushing back unsuitable referrals to the designated referrer became part of regular activities of decision making. Community care staff felt abandoned when individuals were left to navigate rapidly changing processes in health and social care without streamlined communication channels and a lack of overall organisational support. One of the participants pointed out:

Due to the unique environment, there was real concern about how we could safely support people. Many of the people we accepted for transfer had already been discharged by the time we were in the position to accept them. Even on the day we received our first patient we were still struggling to procure essential equipment. Things often felt unnecessarily challenging. The familiar challenges from my previous health-care role around accepting people from referrals and the subsequent 'push back' from these decisions became a regular part of the day

[Participant 2].

The unstable environment led to staff leaving the organisations including registered nurses, posts which the managers of the

facilities had struggled to fill before the COVID-19 pandemic. The pandemic engendered national challenges, but the purported lack of support made some of the community care staff's roles less desirable. Participants echoed:

We were still recruiting into posts and yet were under a huge amount of pressure to open our service early, to facilitate the transfer of patients from the acute hospital wards. We actually had two members of the registered nursing team (a post that has been a challenge to recruit into due to the reduction in registered nursing numbers) leave prior to opening

[Participant 1].

One colleague resigned as [they] did not think the health care assistant role took [their] career in the right direction. Another has resigned and gone to work in retail

[Participant 5].

3.2 | Transitional shock

Induction processes for delivering a community-based model of dementia care were ongoing before the outbreak of the COVID-19 pandemic and the team-building exercise awaited recruitment to some staff posts. The anxiety surrounding the possibilities of being infected with COVID-19, protecting family members, and ensuing protocols caused an unstable environment for newly recruited staff. One of the participants said:

We were a brand new team that had never worked clinically together before. The team dynamics were challenging, as we were entering the 'storming' phase of team building. The pandemic presented with another challenge, as teams were trying to deal with so many relative unknowns. There were so many personal feelings about how the pandemic was impacting the lives of the team

[Participant 5].

Participants affirmed the struggle with the obligation to swiftly engage with roles they were not well prepared for, which raised levels of stress and anxiety. Applying a clinical care approach in an environment designed to promote independence constantly engendered states of confusion and the contentions around what staff could and could not do were overwhelming. Participants stated:

I was still on a steep learning curve myself. I had little to no knowledge of the systems and processes that would equip me within my role and support my decision-making. To balance this with such an unknown health and social care landscape felt impossible

at times. There were demands and requests from so many sources, the acute trust, the local authority, the staff...

[Participant 1].

Due to COVID, we have ended up with patients that we would not otherwise have had. Our model of care was meant to be promoting independence and promoting positive risk taking for people living with Dementia. We are now 1-1 24/7 with all our patients and although we are trying to keep people as independent as possible it's not how it was meant to be

[Participant 6].

Job dissatisfaction became imminent and the longing to return to roles staff were originally recruited to perform grew across staff bands as the future seemed uncertain. Participants recounted:

It has been very stressful for me. It is evident that other staff have been stressed across all bands which has displayed in various ways. The disappointment amongst staff that we are not able to work to the [dementia care] model is evident in conversation with some staff stating that they will be looking for alternative employment if there is no end in sight to this way of working

[Participant 4].

For me personally, the role I have been redeployed into does not offer fulfilment and there is no patient contact which I miss dreadfully. I will do the best I can here, of course, but at the moment the role is not clearly defined

[Participant 5].

Induction procedures for the community care workforce recruited for a community wellness model of care focused on supporting residents as opposed to acutely ill patients. Staff raised concerns about expectations, which participants reported were not heeded. One of the participants stated:

I have struggled in my mind with having to work to a clinical model in a role and an environment that was not established for that purpose, with a lack of support from the Trust that is making the decisions. I have felt that management from the Trust ignores our viewpoints and valid anxieties. I feel we have not been supported by the Trust as professionals. Processes were not supported by the Trust, and we have been very much left to work it out ourselves. As a new team we have been finding our way. Many processes in place are as a result of COVID-19 which are being felt nationally, but many that we have had to

adapt due to the lack of Trust support are not what we would wish to be doing

[Participant 4].

3.3 | Moral dilemmas

Participants retold encounters of making decisions contradictory to fundamental values in health and social care. The community care staff signed up to the ethos of positive risk-taking to promote the independence of people living with dementia. Nonetheless, patients discharged to the sites did not consent to the unique layout of the facilities. Patients were subjected to 24 hr of one-to-one monitoring to avert the risk of serious events over which some patients raised discomfort. One participant recounted:

These patients are not here as long-term residents who have agreed to the [dementia care] ethos of positive risk. They were not given a choice about coming here and there are potential risks involved with the layout of the site that these patients are not expecting. It has also reduced the patients' ability to be independent with the simplest of tasks and one has stated that she feels she is being watched the whole time

[Participant 3].

Some patients transferred directly from hospitals had not had contact with family for a while and thus manifested needs for stimulation, security and emotional support. The patient care approach individual staff applied bifurcated into intuitive, purely clinical and a blend of wellness and clinical strategies, options which split staff's commitments into disarray. Community care staff found themselves caught between protocols and person-centred practice. Patients seemed to benefit from the blend of wellness and clinical care approach that some staff adopted as one participant stated:

We are using our skills and the strong personal feelings that made us want to work [here] to make sure each patient is benefitting from individual assessments to meet their needs

[Participant 3].

Managing the first deaths was an impetuous experience that participants recounted as both challenging and illuminating. Community care staff had to learn old and new procedures for reporting and verifying death in a pandemic and the procedures for end-of-life care challenged clinical empathy as one participant reported:

This first death (although anticipated and well managed) challenged us as a new team. There were new processes to learn, which had changed during the pandemic, as well as being a new process for us to

learn as a nursing home provider. I feel that the care within the wider organisation has been a challenge, as there have been many decisions made that have challenged ethics and clinical compassion

[Participant 1].

4 | DISCUSSION

The COVID-19 pandemic exposed the world to possibilities of uncertainty in healthcare systems and the intricacies of connecting health and social care. The current study explored community care staff experiences of role transition in supporting the discharge to assess model in England. Hierarchical social structures hold the power to restrict or facilitate options for individuals and the nature of power relations influence individual outcomes (Dowding, 2008). The community care staff's role transition was actualised in contexts of current crisis preparedness, transition shock and moral dilemmas.

Present crisis preparedness concerns the organisation's ability to manage an immediate crisis (Carmeli & Schaubroeck, 2008). Community care staff's recounted experiences highlight a response to an imperative to repurpose the dementia care facilities with a lack of collective belief in the capacity of the organisations to implement the change. Compulsion is effective only within limits, for under extremes, it undercuts the power it ought to preserve (Florczak, 2016). A lack of resource and environmental assessments for effective implementation of change identify the inherent use of dominant logic and power asymmetries in health systems governance (Bigdeli et al., 2020; White et al., 2011). Leadership roles assigned to Community NHS Trusts to coordinate rapid hospital discharge (Lewis et al., 2020) handled community care settings as actionable parts instead of a constituent of the whole playing a vital role in the system's patient flow. The top-down approach in health system governance, often associated with controlling central heating systems, seldom yields desirable outcomes (Attwood et al., 2003). The D2A model turned into a disorderly competition embodying forward and backward push of patient referrals with associated system risks. A system at a critical point carries a high level of connectivity between its subunits and parts of the whole depend on each other to manage a crisis effectively (Rickles et al., 2007). The cracks in UK's health system governance gaped widely when procurement processes stifled essential patient care procedures because the hierarchies of the NHS misaligned with the local government-driven social care system (Humphries, 2020).

Transition shock often used to concern new nursing graduates involves experiences of doubt, confusion, loss and disorientation in the process of adapting to a new role (Duchscher, 2009). Negative experiences in role transition are often associated with job dissatisfaction, lack of empowerment and a lack of organisational support (Chargualaf, 2016). The disparity between what staff were asked to do and what they were able to do particularly within resource limitations in community care settings glared without a unified scope of practice framework. A recent study identified that patients admitted

to the hospital with COVID-19 presented with increased care needs at discharge and frailty correlated strongly with increased patient acuity at discharge (Hewitt et al., 2020). However, limitations in an individual capacity, motivation, explicit communication and the environment which mediate expectations in role transition (Allen & Van de Vliert, 2012) challenged staff's commitment to implement the change. Power relations also entail an individual's will to act in a way of choice, within constraints of social structures for maintaining order (Dowding, 2008). Nonetheless, specific conditions determine the actualised events wherein casual powers generate different events (Sorell, 2018). Some of the community care staff persevered through the commitment to implement the mandated change, whereas some chose to seek other employment opportunities. Joining teams in unfamiliar roles was not an unexpected occurrence amidst the global health crisis. However, the lopsided discourse on experiences of healthcare staff in hospital settings (Al Thobaity & Alshammari, 2020; Ardebili et al., 2020; Liu et al., 2020; Vindrola-Padros et al., 2020) distracts holistic improvements required for effectiveness in cross-sector systems governance. Mutual encouragement connected community care staff to persevere through individual, team and organisational difficulties of discerning decision making. On the other hand, the shared competence developed neither guarantees the right skills mix for patient safety nor expected standards of quality of patient care in resource-constrained settings. Staff's mere coping clouds the glass of wider issues concerning health system governance and system resilience (Topp, 2020).

The likely outcome of implementing change is the success witnessed in the implementation (Weiner, 2020). The lack of concrete structures to negotiate to contribute and participate in patient care was overbearing for staff and service users. Situations presenting with two or more moral values, one of which an individual contravenes irrespective of the course of action constitute moral dilemmas (Kvalnes, 2019). Accepting critically ill patients without the right equipment for effective patient support proved as challenging as pushing back referrals without bed availability warranted at the destined referrer. Power relations and agency moderate system function; thus enhancing the resilience of health systems is contingent on the choices and actions of leading actors and networks with a direct influence on the system (Topp, 2020). The patients' voices were silenced without the usual advocacy from family carers due to visiting restrictions. For instance, a significant percentage (61%) of people discharged from hospital in England during the pandemic did not know about their discharge arrangements (Oliver, 2020). Community care staff had the power to reject inappropriate referrals, but the tension engendered prolonged experiences of moral distress. System governance is not designated to simply imply power over the control of resources, but it also involves the collective action of all actors when considering rights and obligations (Meessen, 2020). Structures and resource availability inform the organisational members' joint evaluation or readiness to implement change (Weiner, 2009). The empirical events community staff experienced under different conditions highlight both low organisational readiness for change

and poor crisis preparedness of the facilities repurposed to support the D2A model. On the contrary, mechanisms influencing the three contextual experiences (organisational, individual and service user) identify the fragile state of England's health system governance for optimising capacity during the COVID-19 pandemic. The standard expectation of any organisational leadership is the ability to establish robust crisis management and recovery systems irrespective of the uncertainties about potential crises (Carmeli & Schaubroeck, 2008). However, learning from the failings of the existing health system governance will improve the resilience of the NHS and restore the public's dwindling confidence in the health and social care delivered in the community.

4.1 | Methodological limitations

The study employed a case study design that explains aspects of the unique case, which may not be transferable to other community care settings. The organisational readiness for change theory with health system governance however illuminates causal mechanisms of COVID-19 response experiences and outcomes of other community care settings. The study registered a low response rate (30%), which we consider to be a variable in criterion sampling and an observation confirming community care staff attrition established in the study. Criterion sampling offers limited opportunities for further sampling when no more potential participants meeting the criterion for the case study can be identified. The method for condensing narrative data to capture and present the most frequently reported experiences could have omitted details that were meaningful to individual participants. This is an ongoing power contention in narrative research which is still complex to reconcile (Florczak, 2016).

5 | CONCLUSION

Staff's perseverance with implementing change demonstrates high preparedness for organisational change (Weiner, 2020). Nevertheless, mandated implementation left less room for community care staff to negotiate options. The study findings support the proposition that health system governance influenced community staff's role transition in response to the COVID-19 pandemic. The outbreak of the COVID-19 pandemic might have limited opportunities for the health system governance framework triad to table and discuss interests for collective action. However, the normative dominance that the control over resources and centrally determined health system priorities ordain require reviewing to enable optimal health and social care cross systems' capacity and resilience.

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CONFLICT OF INTEREST

Authors have no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

Research data are not shared to maintain ethical standards.

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