British Geriatrics Society
Improving healthcare
for older people

Capturing beneficial change from the COVID-19 pandemic

Response from the British Geriatrics Society

Introduction

This report has been written in response to a request from NHS England and NHS Improvement for examples of beneficial innovations across the NHS that have been implemented during the COVID-19 pandemic and should be retained as the NHS starts to resume business as usual. COVID-19 has been the biggest challenge faced by the NHS in its history and many services have had to think on their feet to cope with the unprecedented demand for services and the need to keep patients and staff safe from the virus.

The British Geriatrics Society (BGS) is the membership association for professionals specialising in the healthcare of older people across the UK. Founded in 1947, we now have over 4,000 members, and we are the only society in the UK offering specialist expertise in the wide range of healthcare needs of older people. Our members are geriatricians, nurses, GPs, old age psychiatrists, allied healthcare professionals and researchers providing high quality care for older people as part of a multidisciplinary team during acute illness, chronic illness, rehabilitation and at the end of life, both in hospital and community settings.

The COVID-19 pandemic has disproportionately affected older people – around half of diagnoses have been in people aged over 65 and nearly 90% of deaths have been in that age group. As such, our members have been at the forefront of this pandemic, working in acute, primary and community care with older people who have COVID-19 and continuing to help people without COVID-19 to manage their long-term conditions and remain healthy. They have implemented changes to practice to enable them to continue to provide high quality care to their patients while ensuring that they and their patients are protected from the risk of contracting

COVID-19. Many of these changes have shown better ways of working and our members believe they should be retained and shared more widely as we move out of the pandemic.

Process

From March onwards, we have been hearing from our members about examples of innovations and new ways of working that have been implemented to cope with the unique demands of providing healthcare during a pandemic. Our members have told us that barriers to innovation that they previously experienced, particularly regarding technological innovations, have been removed during the pandemic and it has been easier to implement change than in 'normal' times.

Through our Special Interest Groups and communications with our members, we asked for examples of beneficial changes to practice that members have implemented during the pandemic. Members were asked to complete a form stating what the innovation was, the difference it made to staff, patients and carers and what they would do differently if doing it again. The responses received were analysed by BGS staff and members and organised into the themes provided in this report. The responses we received are from across the country and across a range of settings.

We have organised the responses we received into ten themes. For each theme we have provided a short description of the innovation, one or two examples of this innovation being implemented and a brief outline of the benefits to patients and staff. Where possible we have also added links to BGS publications and groups that support the innovation. We conclude with details of the key enablers that are present throughout the themes and detail on how these innovations can be sustained nationally to ensure that the lessons learned in the pandemic are not lost.

1. Proactive anticipatory care for older people with frailty

Anticipatory care helps people to live well and independently for longer through proactive information, advice and support to stay well and to manage their health conditions. People who may benefit from anticipatory care are generally identified using validated tools combined with professional judgement of their physical and psychological health needs and social circumstances. Identifying populations with greater needs and higher risk of adverse outcomes allows for better targeting of tailored interventions.

Pathfields Primary Care Network, Plymouth

The practice serves 30,000 patients and has already introduced a computer-based case-finding tool that prompts primary care clinicians to assess and identify patients with mild, moderate or severe frailty during routine primary care consultations. Once identified, staff note the patient's frailty status in the GP electronic patient record along with their place of residence (own home, supported living, care home) and whether the

patient is housebound. As this clinical information had already been collected over the last year, the practice had in place a useful population health management tool to support anticipatory care during the pandemic.

The Primary Care Network proactively targeted patients with frailty who were at higher risk of developing an acute illness or experiencing significant deconditioning during lockdown. The tool identified patients who were not otherwise on the government's shielding list and therefore not receiving centrally coordinated support packages. This population was further segmented into three groups to tailor appropriate preventative interventions and anticipatory care:

- Clinicians contacted patients with severe frailty to discuss advance care planning.
- Social prescribers telephoned patients with moderate frailty who were housebound to provide information and advice about staying healthy, active and connected at home, and to offer support to access food and medicines during lockdown if required.
- Patients with mild frailty but not housebound were sent health and wellbeing information by post and by bulk SMS text messaging.

Benefits

To date around 10% of the 1500 patients who received calls were identified as needing some form of practical support. Social prescribers' local knowledge and links to community and voluntary organisations helped them rapidly organise the required support for those who were housebound. They also used their motivational interviewing and health coaching skills to encourage people to exercise, maintain social and digital connections and stay healthy at home. However many of the resources and services to promote mental wellbeing, social connections and exercise are delivered online and currently exclude older people who are not digitally connected. This has prompted plans to mobilise greater support for digital inclusion going forward. Early identification and interventions for older people with frailty helps avoid more intensive treatment and possibly hospital admission and is therefore a cost-effective approach for this population.

BGS resources

- The BGS's *Healthier for Longer* report outlines how healthcare professionals can help older people to stay healthy and independent for longer.
- The *Keeping Older People Safe and Well at Home* resources aim to reduce deconditioning and falls and help older people to maintain physical and mental wellbeing.
- The Paper Boat is a blog by a BGS member explaining the concept of frailty.

2. Urgent primary care response

Around 10% of people over 65 are living with frailty, a distinctive health state in which multiple body systems gradually lose their in-built reserves, resulting in greater risk of adverse outcomes after apparently minor illness. Older people need urgent assessment when such a crisis occurs but often want to remain at home if they can. An effective response requires urgent triage and assessment by experienced and risk-tolerant clinicians with timely support from different disciplines working together to support patients, families and carers.

Primary Care Networks enable general practices to work together to deliver this urgent response with professionals from other community services, social care and the voluntary sector and to provide continuity and coordinated care for people with complex needs.

Urgent multidisciplinary response by a Primary Care Network, South East England

A single GP practice operates from three sites in the Primary Care Network (PCN) and serves 40,000 patients and seven care homes. The network established weekly multidisciplinary hub meetings with colleagues from community services, voluntary sector, mental health and social services to discuss patients whose care is particularly complex and requires advice or support from different disciplines. As COVID-19 increased the number of older people with complex needs being managed at home or in care homes, hub multidisciplinary meetings are now held daily. These 30 minute "mini-Hub huddles" allow professionals in the primary care network to discuss and plan urgent care together.

The practice also introduced a dedicated GP-led multidisciplinary team to provide rapid telephone triage and a domiciliary response for people shielding or with complex needs. The team includes three GPs, three paramedics, two practitioners with skills in managing frailty and palliative care, two social prescribers, a team of practice nurses and the practice administrator. They meet daily at 8.30am to discuss patients who need urgent care and to review the progress of those managed during the previous day. The team can respond from 8am to 6.30pm five days per week and link closely with other community providers out of hours.

Benefits

Regular communication has improved information-sharing and access to timely support. Patients benefit from rapid access to intensive support at home from experienced clinicians who are knowledgeable about frailty and in managing people with complex and frequently changing needs. Urgent issues are dealt with more effectively by the right professional and with the option of home visits instead of attending the surgery. Frailty practitioners also provide telephone advice and support to local care homes and coordinate care for people on the palliative register or who have very complex care and support needs. Social prescribers provide telephone support and

advice to people who need help for food or medication delivery or to manage their mental wellbeing or caring responsibilities.

BGS resources

- The BGS's *Position Statement on Primary Care* sets out how primary care can deliver better health outcomes for older people.
- The BGS's GeriGPs Group brings together GP members of the BGS who are passionate about improving healthcare for older people.

3. Specialist-led assessment and treatment at home

Older people with frailty are at particular risk of adverse outcomes from hospitalisation such as healthcare-associated infections, falls and delirium. Hospital at Home is a short-term, targeted intervention that provides acute care at home, equivalent to the level of care that would be provided within the hospital. The model works best when it is part of an integrated acute and community-based service led by experienced senior clinical decision-makers working within a multidisciplinary team that has excellent links with other community services, rehabilitation and intermediate care.

Hospital at Home, Wirral

A two-month pilot of Hospital at Home was a collaboration between Wirral University Teaching Hospital NHS Foundation Trust and Wirral Community Health & Care NHS Foundation Trust. An established rapid response team of therapists, healthcare assistants and a social worker was enhanced by a consultant community geriatrician and nurse prescriber to create a new service for acute treatment at home or in a care home. The team drew on several other community services: paramedic, home oxygen administration, pharmacy, outpatient parenteral antibiotics, and end of life care. Staff used virtual ward rounds, videoconferencing and multidisciplinary meetings to exchange patient information and develop and update treatment plans for their shared caseload.

Frailty Home Treatment Service, Kent

A similar initiative was introduced in Kent to enhance and extend local rapid response and multi-agency support to provide a 7 day / 12 hour crisis assessment and home treatment service for older people with frailty. The team provide consultant-led comprehensive geriatric assessment (CGA) and multidisciplinary hospital-level acute treatment or end of life care as appropriate. As a result, older people can be supported to remain at home or in their care home in line with their wishes.

Benefits

In the Hospital at Home pilot, only 10 of 149 patients receiving the service needed transfer to hospital. The remaining patients received acute care at home including intravenous antibiotics, subcutaneous fluids, and home oxygen with rapid access to diagnostic investigations as a day case if required. Healthcare assistants provided crisis support for family carers and supported rehabilitation alongside the therapy team. Where appropriate, palliative and end of life care was provided at home. The pilot allowed different professionals and teams to see the excellent outcomes they could achieve by working together and has helped to accelerate progress towards a truly Integrated Care System on the Wirral. During May, 94% of 360 people referred to the Frailty Home Treatment service were able to remain at home with support from their usual carers and family. They received high-quality person-centred treatment and care in a way that respected their wishes. Face to face support helped staff working in care homes understand infection control guidance and use of protective equipment. Staff who work in the team report high levels of job satisfaction.

BGS resources

- *Integrated care for older people with frailty* is a collaborative publication between BGS and the Royal College of General Practitioners and is designed to support GPs and geriatricians in responding to the challenge of rising levels of frailty.
- The Community Geriatrics Special Interest Group of the BGS brings together members working on frailty and managing long term conditions in the community.
- This blog by a BGS member outlines the benefits of integrated care, specifically during the pandemic.

4. Coordinated multi-agency support for care homes

Approximately 400,000 older people in the UK live in care homes and a significant proportion are living with frailty. Most care home residents have cognitive impairment, multiple health conditions and physical dependency and many are in their last year of life. Up to 40% of emergency admissions from care homes are considered potentially avoidable if care homes had access to enhanced healthcare support. In 2016, the Enhanced Health in Care Homes (EHCH) Framework evidenced how to improve health and care support through collaborative working between health, social care, voluntary sector and care home partners.

Community network to support Care Homes, Southwark & Lambeth

A multi-agency strategic group prioritised support for 19 care homes with over 1300 beds across two London boroughs. A care home network was established involving care home staff, GPs, palliative care clinicians, geriatricians, psychiatrists, community pharmacists and Clinical Nurse Specialists. A COVID tracking system shared routinely collected data to better target support. Clinical support included advice from a

geriatrician on call 24/7, flexible GP/geriatrician co-working, and coordination of additional support from Hospital at Home, psychiatry and palliative care teams. WhatsApp messaging, used with appropriate Information Governance, enabled rapid sharing of guidance, educational tools and organisation of local point-of-care COVID-19 testing in care homes.

Multi-agency support coordinated by a team of senior nurses, Kent

The CCG, Community Trust, Acute Trust, Local Authority, Hospice, regulators and Age UK collaborated to provide a single point of contact for care homes to access comprehensive coordinated support. The Clinical Development Managers (CDMs) in the CCG co-ordinated the response by all partners through a daily multi-agency meeting and proactive calls to care homes at least weekly. This arrangement streamlined access to support for anticipatory care planning, treatment escalation plans, drop-in visits and training. A WhatsApp group between care home managers and CDMs in each area enabled sharing of information, provision of peer to peer support and rapid escalation of concerns about infection or clinical risk in a specific facility.

Benefits

Multi-agency collaboration has enabled speedy access to a wide range of specialist input, prevented hospital admissions when appropriate, and provided timely end of life care. Care homes staff now have a stronger voice in shaping what they need from health colleagues, better access to support and training when they need it, and a greater feeling of community. Specialist frailty and community services have ensured more treatment escalations plans are in place, reflecting the care needs and preferences expressed by residents, carers and families. Relationships between professionals have improved, resulting in better sharing of information across partners, greater coordination and more integrated workforce planning.

BGS resources

- The BGS's guidance on *Managing the COVID-19 pandemic in care homes for older people* has been developed to help care home staff and the NHS staff who support them to manage the pandemic.
- This blog by a BGS member outlines how integrated care is best for people living in care homes.

5. Person-centred advance care planning

Advance care planning (ACP) is an opportunity for patients to lay out their values, beliefs and preferences relating to everyday life as well as treatments at the end of life. For ACP to be effective, patients must be informed about the prognosis and its uncertainty, and the impact, limitations and burdens of medical intervention intended to sustain life - from antibiotics and intravenous fluids, to organ support, clinically assisted nutrition and hydration, and attempts at cardiopulmonary resuscitation. The process should begin as

early as possible, evolve as the person's condition changes and be driven by what matters to the person. It must be done honestly and sensitively, ideally following comprehensive assessment and as part of proactive and person-centred care planning.

Remote comprehensive assessment and advance care planning in Kent

At the start of the COVID-19 response, some members of the Kent Community Frailty Team were required to shield but were able to continue to contribute to the team by undertaking comprehensive geriatric assessments and treatment escalation plans remotely from their homes. The clinicians contacted patients and carers by telephone calls to their homes or care home. Decision-making was informed by remote access to test results, community and hospital records and liaison with other services. If communication or cognitive impairment limited the individual or carer's participation by telephone, a face-to-face assessment was arranged. A new administration system was established to ensure the remote assessments and care plans were visible across the IT system.

Early identification of frailty and treatment goals, Kettering General Hospital, Trent

The Clinical Frailty Score was used to identify patients with frailty on admission to hospital with suspected COVID-19 and, in turn, to prompt proactive discussion about treatment goals with patients and/or their families in order to ascertain and record their views on treatment options. These conversations included consideration of risks and benefits of different interventions and the likelihood of successful resuscitation in the event of a cardiac arrest. Where appropriate, DNACPR and ReSPECT forms were completed to provide a record of these proactive shared decisions.

Benefits

Feedback in Kent has been very positive with most patients welcoming the opportunity to be assessed in their own home with carers and family involved and without risk of infection from visiting clinicians or attendance at a healthcare site. Shielding clinicians reported high levels of satisfaction with their role and successfully completed 102 virtual assessments and treatment plans from March to May 2020. In Kettering, early identification of patients with frailty at higher risk of death or other adverse outcomes prompted proactive and sensitive dialogue with patients and families. This helped staff respect their patients' wishes and avoid harm and distress for patients and families from futile interventions. The process enhanced staff safety by reducing unwarranted risk of infection with COVID-19 during aerosol-generating procedures associated with futile cardiopulmonary resuscitation.

BGS resources

- The End of Life Care in Frailty resource series aims to support clinicians and others in considering the needs of and providing high quality care for frail older people as they move towards the end of their lives.
- The End of Life Care SIG is for BGS members with a specific interest in care at the end of life.
- This blog by a BGS member outlines why good end of life care is so important for people with frailty.

6. Age-attuned acute care

Older people have a high risk of delirium - an acute deterioration in mental functioning arising over hours or days, triggered mainly by acute illness, surgery, trauma, or drugs. Delirium contributes to poor outcomes including falls, increased length of hospital stay, new institutionalisation, and mortality, and may cause considerable distress to patients and families. Isolation, PPE and the aesthetics of the ward environment may exacerbate the risk and consequences of delirium across the hospital, particularly for older adults with existing cognitive and sensory impairment.

Learning from the paediatric ward ethos and practice at UCH, London

During the COVID-19 outbreak, a paediatric ward was rapidly repurposed to manage adult patients with acute illness. The existing paediatric nurses and play specialists remained and worked alongside the older adult team. The bright, creative and fun ward aesthetic contrasted with aesthetic deprivation that is common in adult inpatient wards. Holistic interventions were woven through the ward routine and included cognitive stimulation, individual and group activities, and promotion of sleep with the use of calming lights and soothing music for patients showing signs of distress. The ward environment and ethos improved well-being in the older adults.

Integrated end of life care for patients with COVID-19, Nottingham University Hospitals

A joint initiative between the Geriatric Medicine and Palliative Care departments repurposed a suitable ward to deliver dedicated end of life care in the acute hospital. The unit was led by the geriatric medicine department with seven-day medical cover and outreach to acute geriatric wards by two specialist registrars. Specialist palliative care clinicians provided seven-day support for family discussions, rapid discharge plans, symptom advice and medication reviews. The ward manager developed links with community volunteers to enrich the clinical environment and iPads were purchased to facilitate video calls between patients and their loved ones. The relatives' room had refreshment facilities and advice on how to reduce infection risk from visiting. A family discussion board supported communication and requests for additional support from chaplains or faith groups. Families and staff had access to a bereavement centre and clinical psychology support.

Benefits

In both examples, patient and staff experience improved in an enriched ward environment. Patients felt less isolated and displayed reduced levels of distress or agitation. Adopting a holistic approach and enriched care environment could help prevent and manage delirium in acute care, with considerable benefits for patients, families, staff and the system. Many families wrote about the high-quality compassionate care and dignity provided by staff in the end of life care ward. A strong sense of pride and teamwork helped offset the emotional burden of working on the ward during the pandemic. Staff rapidly up-skilled through a blend of formal and peer to peer learning and reported increased confidence in managing symptoms, medication, communication and distress.

BGS resources

- The hospital wide comprehensive geriatric assessment project aimed to inform NHS managers, clinicians, patients and the public about the best way to organise hospital services for older people with frailty.
- *Managing delirium in confirmed and suspected cases* provides specific guidance about the management in delirium during the pandemic.
- *Patients don't just have dementia* is a blog by a BGS member outlining the benefits of holistic care for people with dementia.

7. Safe, effective and timely transfers of care

Safe, timely discharge and the avoidance of early readmission are important markers of high-quality acute care and effective integration between hospital and community services. Delays in transfer of care once older persons are clinically ready to leave hospital increases their risk of deconditioning and hospital-associated harm, reduces vital inpatient capacity and increases system costs. Sustainable solutions require proactive coordinated discharge planning and timely access to integrated transitional care and community intermediate care services.

Integrated Discharge Assessment Unit, Royal Derby Hospital

During the pandemic, revised discharge guidance was introduced to optimise bed capacity and manage the expected increased demand for acute care. These new arrangements saw Derbyshire Community Health Service responsible for securing discharge arrangements for all patients, and the NHS fully funding new or extended community health and social care packages. To support the ambitious standards for completion of discharge arrangements, the previously underutilised Discharge Lounge was relocated and the associated staffing was enhanced to develop an integrated 'Discharge Assessment Unit.' This initiative brings together the Integrated Discharge Team with additional support from nursing, pharmacy, dietetics, acute and

community occupational therapists to co-ordinate discharge planning and ensure a safe, timely and positive discharge experience for patients and their families.

Patients move to the Discharge Assessment Unit within one hour of being identified as medically optimised with the aim of being discharged from hospital within two hours. Therapy assessments take place at home, on the day, or the day following discharge. The 'pull' into the community comes from experienced community services. As a result, within hours of becoming medically fit to leave hospital, patients are able to be discharged at the right time, on the right pathway, with the correct follow-up, documentation and medications.

Benefits

The redesigned pathway eliminated delays, released additional acute capacity and contributed to the system effort to save lives. The activity of the Discharge Assessment Unit quadrupled during weekdays and the previously limited service is now fully functioning at weekends. The number of patients experiencing delayed transfer from hospital reduced from over 80 per day to less than 20 per day. Community services rapidly assess and review patients in the community, reducing the risk of deconditioning in hospital. This improves recovery and outcomes for patients, reduces the number of people who require long-term care and support, and reduces costs across the whole system. Co-location of acute and community staff improved information-sharing, reduced duplication and enabled professionals to gain insights into working across the system. This is building trust and enabling practitioners to constructively challenge each other. Having an ambitious shared goal helped partners solve problems together and collectively push their boundaries. The landscape of integrated working has radically changed. Each member of the multiagency team has a 'can do' attitude that is realising the value and potential of whole system working.

BGS resources

- The Frailty in Urgent Care Settings Special Interest Group brings together members with a specific interest in this area.
- The Community Geriatrics Special Interest Group of the BGS brings together members working on frailty and managing long term conditions in the community.
- This blog by a BGS member discusses the importance of getting hospital discharge right for patients.

8. Optimising rehabilitation and recovery

There is growing awareness of the complex rehabilitation needs of survivors from COVID-19, and their risk of long-term disability. With symptoms affecting multiple systems, the need for support and treatment from many rehabilitation disciplines is clear. Currently, people are contacted after discharge from Intensive Care by a number of different professionals from community, inpatient and outpatient services. With demands for rehabilitation increasing, optimising capacity, productivity and reducing duplication through an effective rehabilitation pathway will be critical for recovery.

Proactive rehabilitation in Health and Ageing wards, King's College Hospital, London

The health and ageing therapy team were concerned about patients with ongoing needs for rehabilitation who are not appropriate for transfer to a post-acute rehabilitation setting because of COVID-19 issues. In the acute setting, such patients are often deprioritised for therapy time because of competing demands for therapists to assess and treat new admissions. The team systematically identified patients who would benefit from daily or even twice daily physiotherapy and prioritised them for continued rehabilitation input to maximise their functional potential as much as possible prior to discharge. A therapist member of the health and ageing team was supported by rehabilitation assistants and healthcare support workers.

A multi-disciplinary COVID-19 rehabilitation screening tool, Yorkshire

With pressures on intensive care capacity and many patients with intensive or complex needs also managed on other hospital wards, there are concerns that some patients may miss out on assessment for vital follow-up rehabilitation. Patients identified may receive a large number of calls from each profession asking similar questions on top of discipline-specific issues. This may increase levels of stress and anxiety for patients and reduce participation and uptake of services. The potential harmful effects of multiple repetitive questioning regarding recent illness is prompting interest in multidisciplinary screening and assessment tools. The risk of face to face contact is driving expansion of telephoned-based screening. A multi-disciplinary telephone screening tool was developed by Airedale, Leeds and Hull NHS trusts to identify the rehabilitation needs of COVID-19 survivors. The COVID-19 Yorkshire Rehabilitation Screen (C19-YRS) tool is used for patients once they return to the community. https://www.acnr.co.uk/2020/06/c19-yrs/

Benefits

Continuing rehabilitation in the acute setting for patients awaiting discharge resulted in improved patient recovery, sometimes against clinician expectations, and reduced the level of community support required for discharge. This further highlights considerable unmet need for rehabilitation for patients following acute events and COVID-19 related illness. The COVID-19 Yorkshire Rehabilitation Screen tool reduced professional duplication, and better coordinates and targets community rehabilitation provision by different disciplines and community partners. Patients feel reassured by having a thorough review of their rehabilitation support and recovery needs in a single call. The tool has now been adopted by over 30 trusts across the country.

BGS resources

- The BGS Rehabilitation Group is a task and finish group assembled to address the issues surrounding rehabilitation and loss of function as a result of the COVID-19 pandemic.
- This BGS blog explains why rehabilitation is so important to older people in acute care.

9. Virtual clinics

Virtual consultations have scaled up during the pandemic allowing clinicians to speak to patients who are shielding, self-isolating or unable to travel to a hospital or GP surgery. Currently around 70% of GP consultations are delivered remotely. Allied health professions and hospital clinicians are increasingly delivering tele-clinics to review stable chronic conditions in selected patients. Although video-consultation aids assessment, diagnosis and communication, telephone consultations may be adequate for many patients, particularly where there is an established relationship with the clinician, and may be more suitable for older people who are not digitally connected.

Teleclinics for older people, East region

All patients scheduled to attend new and return out-patient clinics for frailty, falls, movement disorders and orthogeriatrics were contacted prior to their appointment to explain the need for a tele-consultation instead of a face to face clinic. Patients in care homes were seen in the presence of their formal carers who were able to provide basic clinical observations, weight and information on current medication. Older patients consulting from their own home were often supported by a relative. Sometimes family members enabled the older person to connect using FaceTime. However most of the tele-clinics were conducted using a telephone-based consultation.

Clinicians reported the most challenging clinical scenario was reviewing patients with movement disorders. For all other groups, tele-consultations readily enabled clinicians, patients and carers to review and address the required clinical issue and any associated medication problems. Many of the conversations also considered wider issues such as advance care planning, treatment goals and views on cardiopulmonary resuscitation.

Benefits

Most patients welcomed the opportunity to avoid the risks and burden associated with travelling to hospital for a clinic appointment and were happy to be reviewed by telephone. Tele-consultation facilitated better involvement of family and formal carers compared to the experience of clinic attendance. The less formal and more relaxed setting encouraged shared decision-making conversations. All patients had their medication to hand, resulting in better reconciliation with the list of medicines held by hospital and primary care records and a valuable opportunity to review and rationalise current medicines. This has important benefits for improving patient safety, reducing medicine-related harm and risk of adverse events, including readmissions.

The use of telephone triage, video-consultations and creative solutions to overcome information governance barriers during the pandemic has been welcomed. These innovations must be sustained to enable more clinical services to embed technology in the delivery of care. Clinicians will need support to make the required changes to their roles, relationships and clinical workflows.

BGS resources

- The Telecare, Telehealth and Telemedicine Special Interest Group exists to share experiences and proposals and analyse evidence within the rapidly evolving area of telemedicine.
- The BGS is hosting a webinar about virtual clinics in July.
- This BGS blog outlines many of the ways that virtual communication has been utilised during the pandemic.

10. Digitally-enabled care

The quality and sustainability of future health and care services will be improved by digitally-enabled care that scales up adoption of remote and mobile health monitoring in the community, ensures health and care information systems are fully interoperable and enables clinicians working in different settings to access and interact with patient records and care plans wherever they are based. Advances in clinical decision support and artificial intelligence can help clinicians reliably apply best practice and eliminate unwarranted variation. Predictive tools can support systems to plan proactive care and earlier intervention for specific populations.

Tameside and Glossop Integrated Care NHS Foundation Trust expanded their digital hub to coordinate proactive integrated care and support for care homes

The service is the result of system-wide multi-agency collaboration and joint funding between the Integrated Care Trust, digital health service, Directors of Adult Social Services, Public Health Team, Care Home providers, CCG, general practices, Primary Care Network leads, Health Innovation Manchester and a technology company.

The existing digital hub, previously staffed by nurses and paramedics, was augmented by sessions from a consultant geriatrician and four GPs to create sufficient capacity to provide a 24/7 medical rota for telephone triage and remote assessment support for 41 care homes managing 1850 residents. The digital infrastructure allows videoconferencing and remote monitoring for clinical assessment, advice and management with the option of a visit by GP and /or conveyance to the Emergency Department only if appropriate. The digital hub team can access patient clinical records held in primary care to inform their clinical decision-making. An existing digital app to identify and manage an individual's risk of falls was rapidly repurposed to create a COVID-19 digital app. This enables staff in care homes to identify and record information about residents with COVID-19 symptoms, delirium or a new illness. This information is made available to the hub team in an accessible dashboard that allows real-time prioritisation of residents who require early clinical assessment, treatment and care planning.

Benefits

The digital hub infrastructure and multidisciplinary team have improved support to care homes and their staff during the pandemic by providing direct access on demand to senior clinical decision makers 24/7. A single point of contact for rapid clinical assessment supported more people to receive appropriate treatments and end of life care in their care home, reducing transfers to hospital. To date, 850 care home residents have been managed with the COVID-19 app. The combination of innovative digital technology and additional support from senior clinicians has benefited residents and care home staff and improved the ability of the system to quickly identify and address outbreaks. Earlier introduction and direct alignment to public health and infection prevention efforts may have enabled even more proactive management of the crisis. The digital system is now being rolled out and linked to a system-level dashboard covering the whole of Greater Manchester.

Enablers

The common purpose of responding effectively to the COVID-19 pandemic has prompted rapid deployment of a large number of multidisciplinary-delivered innovations focused on improving outcomes for older people, including those with complex conditions, frailty and cognitive impairment. These span service models ranging from acute care to rehabilitation, long-term, supportive and end of life care, across and between primary, secondary, community health and social care sectors. The enabling functions of shared impetus and re-prioritisation, compounded by a strong sense of urgency, should not be underestimated.

These factors have been crucial in helping teams and systems to work more effectively and efficiently in capitalising on innovations, many of which had already been years in development but some of which had not yet been given room to breathe properly and prove their worth. The uniting objective of the innovations presented by the BGS has been to improve care quality for older people. A number of key enablers emerge from them when considered collectively:

- Shifting national policy focus away from expedited hospital admission towards hospital discharge with greater emphasis on, and support to, primary and community health and social care;
- Supporting senior managerial and clinical leadership to own and deploy solutions rapidly and optimally;
- Ensuring governance support for safe cross-sectoral team working;
- Removing bureaucratic and financial obstacles to facilitate deployment;
- Building services around what is evidentially already known to work and what is needed most;
- Ensuring clarity of service models which include intended outcomes and benefits;
- Sustaining a clear focus on effective and flexible multidisciplinary team working;
- Building from, or re-purposing, existing services where possible;
- Utilising the skills, capabilities and expertise of professionals specialised in the care of people with complex conditions optimally within teams;
- Retaining multidisciplinary communication and team processes despite social distancing;

- Rapidly adopting digital and telehealth technologies to improve timeliness of patient and carer access to teams, and to support efficient communication between teams and across sectors;
- Using outcomes data, staff and patient feedback to drive local continuous quality improvement.

Sustainability

The coronavirus pandemic has reshaped the NHS in ways unimaginable even 6 months ago. The innovation examples we present, driven largely by local leadership, ownership and real-time, agile decision-making provide insight into how we must now learn from and sustain the rapid progress we have made collectively since the beginning of the pandemic.

The COVID-19 innovations identified by the BGS amplify existing best practice in the care of older people with complex needs and in many cases were already in development prior to the pandemic. Importantly they provide insight into a model of integrated care, which is clinically led and locally owned and must now be sustained for future generations, aligned to the primary objectives set out in the *NHS Long Term Plan*[1], the *Long Term Plan Implementation Framework*[2] and *NHS Operational Planning and Contracting Guidance 2020/21*[3]. Specifically, they illustrate:

- How the NHS will move to **a new service model** in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting;
- How patients with complex needs will experience their right to digital consultations[4], and redesigned hospital support[5] which avoids **unnecessary outpatient appointments,** potentially saving millions of trips to hospital, and saving the NHS over £1 billion a year in new expenditure as set out in national planning;
- How **primary and community services** can work together to deal with pressures in primary care and extend the range of local services, creating genuinely integrated teams of GPs, community health and social care staff[6];
- How community health teams can, under new national standards, provide fast **support to people in their own homes** as an alternative to hospitalisation[7];
- How more people can benefit from social prescribing and personalised support for managing their own health in **cross-sector partnerships**[8];
- How same-day emergency care can be provided for older people with complex conditions without the need for an overnight stay[9];
- How cross-sector partnerships between health services working with local authorities, charities and volunteers can expedite hospital discharges to help **free up pressure on hospital beds**[10].

Sustaining and growing these innovations into business as usual now requires redoubling of three existing major policy commitments at national, regional and system levels:

1. Continued commitment to clinical leadership and local system ownership as set out in the 2019 NHS Long Term Plan implementation framework;

2. Continued commitment to target ring-fenced local funding worth at least an extra £4.5 billion in real terms by 2023/24 as set out in the NHS Long Term Plan and the cross-sector national Ageing Well Programme[11] at primary and community services for older people and those with complex conditions;
3. Continued emphasis on multidisciplinary team working as set out in the interim NHS People Plan[12] to transform the way the entire care workforce, including doctors, nurses, allied health professionals, pharmacists, healthcare scientists, dentists, non-clinical professions, social care professionals, commissioners and volunteers, work together.

In addition, it is crucial that all of this work is subject to rigorous evaluation to build new evidence, guide commissioning decisions and ensure continued best value for money. This requires renewed national emphasis on patient outcomes measurement, data collection, benchmarking, audit and service-based research.

The innovations we present demonstrate how effective deployment of well-led and governed multidisciplinary team-based services can support the whole-system step changes required for implementation of the NHS Long Term Plan Ageing Well Programme. They have through necessity focused on four key areas of need during the first phase of the COVID-19 pandemic:

1. **Targeted support to those with greatest vulnerability** through population health segmentation approaches focused on frailty delivered through cross sector partnerships, which is beginning to drive the development of primary care networks;
2. **A clear focus on digitally-enabled proactive care homes support** which optimises care for residents, improved support for staff, better linkage to integrated urgent care, and facilitates system level outbreak management;
3. **Rapid discharge of people, principally those who are older with complex needs**, into community settings for ongoing or end of life care to optimise acute care bed capacity;
4. **Integrated urgent care** to rapidly identify, assess and optimally support older people who are unwell or injured with complex conditions including frailty and cognitive disorders such as delirium.

These innovations can be used to shift policy, planning and practice away from traditional organisational-centric in or out of hospital-based planning to personalised care outcome service planning. They were already required and in development prior to the pandemic. Their rapid deployment and early successes are indicators of their long-term importance to health and social care systems. Using the many existing policy levers to sustain them into business as usual will be a key measure of collective NHS success in managing the post-pandemic recovery phase.

Conclusion

The COVID-19 pandemic has been the biggest challenge to health and social care services since the NHS was formed and it is important that we learn from this experience. While there has been ample attention paid in the mainstream media to the failures and things that have gone wrong, there has been little or no attention paid to the success stories. We must ensure that we learn from the successes and the failures.

Older people have paid a terrible price during the pandemic and thousands of families across the country will never be the same again. We must ensure that the thousands of deaths have not been in vain and that we emerge from this crisis stronger.

The examples given in this report illustrate best practice that could be implemented more widely across the country. We would be happy to work with NHS England and NHS Improvement to provide more information about the examples provided and to help our members to further share their expertise and best practice.

[1] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

[2] https://www.longtermplan.nhs.uk/implementation-framework/

[3] https://www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21/

[4] https://www.england.nhs.uk/gp/digital-first-primary-care/

[5] https://www.england.nhs.uk/elective-care-transformation/

[6] https://www.england.nhs.uk/blog/the-aspirations-for-community-health-care-and-primary-care-networks/

[7] https://www.england.nhs.uk/2020/01/rapid-nhs-response-teams-to-help-people-stay-well-at-home/

[8] https://www.england.nhs.uk/2020/01/rapid-nhs-response-teams-to-help-people-stay-well-at-home/

[9] https://improvement.nhs.uk/documents/6111/SDEC_guide_frailty_May_2019_update.pdf

[10] https://www.england.nhs.uk/coronavirus/publication/covid-19-hospital-discharge-service-requirements/

[11] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

[12] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf