British Geriatrics Society
Improving healthcare
for older people

Capturing beneficial innovations from the COVID-19 pandemic in Northern Ireland

Introduction

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, including more than 100 in Northern Ireland, 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.

This report has been adapted from one 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. Where possible we have provided examples of beneficial innovations provided by BGS members in Northern Ireland. However, we have also retained some of the English examples as there is no reason why these cannot be replicated in Northern Ireland.

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 COVID-19 pandemic has disproportionately affected older people – around half of diagnoses have been in people aged over 65 and more than 90% of deaths have been in that age group.[1] 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 represent the multidisciplinary nature of our membership and include innovations that have been implemented 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.

Acute Care at Home (AC@H), Southern Health and Social Care Trust

The AC@H team is a dedicated Consultant Geriatrician-led multidisciplinary team. Its primary focus is on maintaining older people at home or in nursing or residential care in the event of an acute illness or unexpected deterioration in health. It provides triage, assessment, diagnosis and treatment as an alternative to in-patient care to those at risk of or potentially requiring admission to hospital. The service is consultant-led with nursing staff on duty 9am to 11pm, 7 days a week and medical staff available 7 days a week. The team deliver intravenous antibiotics, subcutaneous fluids, blood transfusions, intravenous fluids and syringe drivers in a community setting. Testing is also available in the patient's home including a bladder scan, ECG, visual acuity and bloods. Allied Health Professional staff also provide immediate assessment and treatment as required.

Domiciliary falls visits – Daisy Hill Hospital, Newry

It was clear that clinics for older people's falls were going to be cancelled at the start of the lockdown due to the large footfall of staff and size of area that it has previously commanded. However, this did not stem the referrals of falls. It was noted that amongst referrals were multiple fallers and those who could be considered high risk. A significant proportion of the first few weeks' referrals reattended emergency departments with a complication of a further fall.

It was felt that the system could accommodate high risk people with clear guidance on isolation and telephone triage. A number of routine questions were asked by a member of the multidisciplinary team including questions about COVID symptoms and self-isolation. Those, who were deemed fit to do so were triaged for a domiciliary visit by a member of the team.

Benefits

Although the AC@H has been operating since 2014, it was seen as part of the solution to the COVID-19 pandemic from the beginning. As a response to the pandemic, 7-day medical cover was introduced allowing for 7-day referrals. Clinics were stood down to allow for staff to be concentrated in the service. Infection control measures were increased, along with PPE education. The team are linked every morning with a meeting chaired by the Medical Director. During the 61 days from 26 March 2020 to 25 May 2020, the team accepted a total of 350 referrals (patients not accepted were given advice and signposting to appropriate services) and during April 2020, the team accepted 205 referrals, an increase of 81% on the same month in 2019.

Of the 350 referrals accepted, 75 were COVID-19 positive, representing 20% of the total caseload. 22 of the COVID-19 patients died while under the care of the AC@H team or within 14 days of discharge. 71% of COVID-19 patients recovered. Only five of the COVID-19 patients were admitted to hospital.

The domiciliary falls visits resulted in a more streamlined assessment, and less need for hands-on work as more team members could view an examination or test and the patient's home could be assessed for safety concerns. This was met with positive testimonials by patients and their families.

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.

Responsive Enhanced Care Support to Care Homes from a Trust and Primary Care Partnership – Northern Health and Social Care Trust (NHSCT)

There are a total of 133 care homes in the NHSCT area which encompasses approximately 4000 residents in this care setting. During COVID-19 some of those residential and nursing homes experienced crises in care situations which required the response of an enhanced Care Support service from the Trust, in partnership with general practice. To reduce care home footfall this process was led by a nominated member of the Trust clinical team utilising iPhone and iPad technology. A GP led a multidisciplinary team in the assessment of the frailest residents as determined by the care home manager, to plan the safest and most appropriate care management. Access to a community hospital was key for those residents most in need of temporary clinical intervention when acute hospital admission was not required. The team consisted of colleagues from nursing, dietetics, speech and language therapy, pharmacy, occupational therapy and physiotherapy along with social work staff who acted as Family Liaison Officers to provide essential communication links with residents' loved ones.

This enhanced support service continued with residents' care plans reviewed regularly with relevant professional intervention. The enhanced support service then transformed to a post-COVID-19 recovery plan of care with resident deconditioning being the most prevalent condition requiring long term management.

Benefits

Enhanced support for care homes has involved responsive engagement between Trusts, the independent sector and general practice. It has meant that care home residents have been provided with the right support in the right place at the right time. The initial responsive service has transformed into an ongoing resident review and post COVID-19 recovery management.

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.

Integrated care for older people with COVID-19, Altnagelvin Hospital

Patients with COVID-19 were admitted to Altnagelvin Hospital either via the Emergency Department or GP Covid Centre. Patients were triaged and assessed for management on a respiratory Covid ward and subsequently or directly admitted to the Acute Care of the Elderly ward. Through daily huddles and reorganisation of Trust management pathways, rapid developments were made in a constantly changing environment. A constant commitment to the ethos of high quality, holistic, patient-centred service delivery to frail, older people was central to the excellent outcomes achieved, through a focus on ensuring multidisciplinary team working and the maintenance of Comprehensive Geriatric Assessment despite the altered working environment.

Geriatric liaison service – Daisy Hill Hospital, Newry

A geriatric liaison service was established to assist the medical cohort with issues relating to frailty and geriatric triage. A Physician Associate was trained to help with the screening and delivery of CGA on the general medical wards. This allowed for the screening of 178 patients over a nine-week period in June and July, with 94 face-to-face CGA assessments performed and treatment plans put in place. Some patients were triaged to rehabilitation units in another locality while others remained within Daisy Hill Hospital either under the care of the geriatric teams or managed under care of general physicians but with specific

recommendations from the older people's care team. This signposting helped significantly in the flow of patients to the correct service.

Repurposing ED – Daisy Hill Hospital, Newry

During the COVID-19 pandemic, the emergency department at Daisy Hill Hospital was relocated, leaving a space available for a Comprehensive Geriatric Assessment (CGA) Team. The CGA team used the space as a rapid access clinic, allowing older adults on the verge of crisis to be seen and assessed while avoiding the emergency department.

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 and visiting

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.

Virtual technology has also been used extensively during the pandemic to allow older people in hospitals and other settings to maintain contact with their families and loved ones who were unable to visit in person.

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.

Virtual visiting – Daisy Hill Hospital, Newry

Virtual visiting via iPad was introduced on each ward in order to improve communications and 'face to face' contact with loved ones. A rota for visiting was created on Google Docs and staff were able to schedule visits with families and ensure that patients had access to the technology required at the allotted time. This also allowed for interactive communication when the MDT needed to talk to families or show how their relative was progressing while in hospital.

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.

Using data intelligence to provide care home support from Trust Services – Northern Health and Social Care Trust

The sharing of information to inform decision-making is a crucial element of the sustained collaborative efforts required to mitigate the ongoing impact of COVID-19 within the care home sector. On direction from the NI Department of Health, residential and nursing care homes are required to provide a single daily update to the Regional Quality Improvement Authority (RQIA) on a range of key variables about how care home services are coping with the impact of COVID-19. The daily update is compiled on an app encompassing key information required to inform and support functions undertaken by Trusts in responding to outbreaks.

Within NHSCT, the care home app information, covering 133 care home facilities and approximately 4000 residents, is RAG rated and tabled at a daily senior community Zoom surveillance meeting where this information is further weighted to determine the level of trust and primary care intervention required for each care home. This intervention can range from a proactive support telephone call by a Trust link worker assisting the care homes in accessing PPE, providing advice on infection, prevention and control measures or responding to staff clinical training needs, to a higher level of intervention involving a Trust and Primary Care Partnership assessment and treatment visit to the care home residents.

Benefits

Use of timely data provide evidence for both proactive and reactive care provision. It has been useful to convene a regular engaged multiprofessional community team to explore and interrogate the data available. This approach has encouraged respectful engagement between trusts, the independent sector and general practice. Surveillance meetings have continued since the first COVID-19 surge with frequency of meetings determined by the level of care home support identified.

The detrimental impact of COVID changes

It is worth noting, in addition to the many examples of innovative changes in the NHS over the course of the COVID-19 pandemic, some services that already existed providing innovative services to older people were paused to make way for COVID-19 specific care. These services were working well and improving care for the people the serve and while we understand the need for them to have been stood down in order to enable the

service to deal with the pandemic, it is important that they are reinstated as quickly as possible to ensure that past gains made in the care of older people are not lost.

BCH Direct – Belfast Trust via the Belfast City Hospital site

BCH Direct was opened in October 2014 to facilitate 24/7 direct admission of older persons to the Older Persons Team. It was developed following an earlier more limited pilot of direct admissions and was endorsed and recommended by a 2014 RQIA review of arrangements for the management and coordination of unscheduled care in the Belfast Trust.

It was recognised that many older people with frailty admitted to the hospital via the emergency department did not specifically need emergency care. Despite primary care often recognising the need for assessment or admission to the Care of the Elderly ward, the only means of accessing that care had been to refer patients initially to the emergency department who may in turn have sought admission to the Care of the Elderly ward. BCH Direct allowed primary care practitioners to talk directly with a senior decision-maker with the Care of the Elderly team. Often telephone advice was sufficient to support primary care decision-making but, if appropriate, arrangements for same or next day assessment and admission could be made. This was arranged in a unit specifically designed to be responsive to the needs of older people. There was a front door focus on rapid Comprehensive Geriatric Assessment incorporating inputs from doctors, nurses and allied health professionals with strong links with the community teams to facilitate early discharge for appropriate patients.

The unit built on its early successes to also allow for direct admissions from the ambulance service and later enhanced its working with the community based Acute Care at Home team with the initial GP referral remaining a single phone call to a joined-up community and hospital service.

The goal was not just to reduce emergency department attendances but to improve the care pathway for older people. This approach reduced duplication of acute assessments, simplified pathways and reduced ward moves as well as inter-hospital transfers of care. The unit aims to avoid some of the harms of hospitalisation. The feedback from patients, relatives, primary care and the Northern Ireland Ambulance Service was overwhelmingly positive. Approximately 2000 patients per year were able to access the specialist geriatric service they needed whilst avoiding attendance at the emergency department and the team won an award for the category of 'Respect and Dignity' from the Trust Chairman in recognition of the care delivered.

With recent team and trust changes in response to the COVID-19 pandemic, and in particular the repurposing of the City Hospital site to 'NHS Nightingale' Status, this service has been temporarily discontinued. The temporary absence of this service has created a disconnect between Care of the Elderly Community and Hospital based teams with seamless transition between the two being much harder to achieve. Once again the emergency department is the main focal point for urgent assessments and

admissions. An early opportunity to reinstate the principles and practices of the BCH model is high on the agenda by primary and secondary care clinical staff, in order to enhance the services offered to patients and their families.

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. 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[2], and redesigned hospital support[3] 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[4];
- How community health teams can, under new national standards, provide fast **support to people in their own homes** as an alternative to hospitalisation[5];
- How more people can benefit from social prescribing and personalised support for managing their own health in **cross-sector partnerships**[6];
- How same-day emergency care can be provided for older people with complex conditions without the need for an overnight stay[7];
- 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**[8].

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 whole-system step changes. 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 the Department of Health to provide more information about the examples provided and to help our members to further share their expertise and best practice.

[1] https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Deaths%20Registered%20in%20NI%20-%20Week%2035%202020.pdf

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

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

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

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

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

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

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