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ACUTE PERSPECTIVE

David Oliver: The pandemic has delivered clinical service innovations worth keeping

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The NHS's response to the covid-19 pandemic has shown how necessity can be the mother of innovation. Although plenty has gone wrong in national policy,¹ and while frontline services have experienced considerable difficulties,² the crisis has also accelerated and enabled the adoption of some practices we might actually like to keep.

Telephone and online consulting: Infection control measures left us with no option but to make far greater use of this. It was already done in primary care and some secondary care clinics, but it became the default for many routine appointments where physically being in the same room wasn't necessary.³ It does raise some concerns, including patient preference, exclusion of patients unable to use digital technology, and the ongoing need for hands-on examination and same room discussions. But for other patients it has improved access, convenience, choice, and flexibility, reducing the need for transport to and from facilities. We'll have to establish a new balance between remote and physical consulting.

"Virtual wards" and other home based models: Policy initiatives and research evaluations already existed in the setting of "hospital at home," rapid home based assessment, and community based ambulatory emergency care,^{4,5} but the imperative to avoid needless hospital admission or attendance brought these models more centre stage. A particular focus on numerous sites around the UK was on "virtual wards" for people with respiratory covid-19 symptoms, who didn't need to remain in an acute hospital bed just so that their symptoms and oxygen saturations could be monitored.⁶

These measures combine remote or self-monitoring of oxygen saturations, reporting of symptoms with telephone support, and the ability for immediate recall if a patient deteriorates.⁷ They've helped thousands of people remain out of hospital. They could be kept, scaled down, and used for other conditions.

Enhanced rapid access to intermediate care and community assessment: We already know that time limited, multidisciplinary, post-acute rehabilitation—either in patients' own homes or in community facilities—is well liked by patients and cheaper than comparable treatment in the general hospital.^{4,8,9} Furthermore, it allows many patients to regain function lost after acute illness or injury, in a friendlier setting.

NHS England's covid-19 discharge policy, as well as locally led innovation and an additional £648m for step-down community services during the pandemic,

anecdotally led to much slicker access to community services, whose capacity had been boosted (although data collection on delayed transfers of care were suspended).¹⁰ The use of "discharge to assess" bedded facilities also became popular, where people's ongoing care needs could be determined after a spell of observation outside the alien acute care setting. We should plan to maintain some of that additional capacity and responsiveness for good.

Joint working and protocols with care homes: The story of mass transfers to care homes from hospitals in the first wave, hundreds of care home outbreaks, and thousands of care home deaths is well documented. Later on, however, this led to a much greater focus on infection control and patient transfer protocols that considered this sector.

Models of enhanced healthcare support for care homes became more widely adopted—relying not just on GPs but on multidisciplinary teams, advanced care practitioners, geriatricians, and palliative care staff—along with rapid interventions that were already established in some parts of the country.^{11,12} This helped people to be cared for within care homes and to stay out of hospital or leave sooner. This is already an ambition of the NHS 10 year plan, and we should build on this progress rather than slip backwards.

Some of these innovations have relied on additional targeted funding, extra capacity, or repurposed staff roles. But the speed of their adoption has also depended on clinicians and managers in local services being given the permission and flexibility to innovate.

So, let us lead change: give us the resources and permissions to do it, and we will.

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