The impact of COVID-19 on older people: Lessons learned for ageing well

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Introduction

Today I'll be talking about:

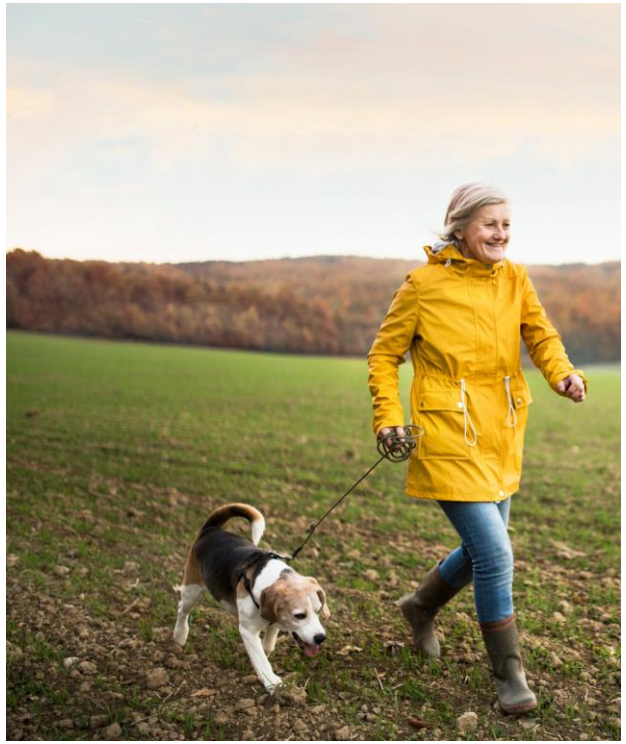
- What the evidence tells us about the impact of COVID-19 on older people
- The support the NHS provided during the pandemic in the community
  - Enhanced Health in Care Homes (EHCH)
  - COVID vaccination programme
  - Discharge to assess
  - COVID oximetry@home
- How this builds on the NHS Long Term Plan: 2hr crisis response, EHCH, anticipatory care
- Future ambitions for community services

What the evidence tells us

[The experience of people approaching later life in lockdown: The impact of COVID-19 on 50-70-year olds in England | Centre for Ageing Better (ageing-better.org.uk)]

This report finds that the lockdown has been tough on some – many people have seen their health deteriorate with more unhealthy behaviours. For the majority of 50 – 70 year olds surveyed, the pandemic has made no difference to their physical health **(69%)**

However, a significant minority – **one in five (22%)** – reported that their physical health is worse as a result of the pandemic.



"I feel my health has deteriorated since lockdown began…not enough exercise and eating unhealthily…not sure if it will impact me in the longterm, but I will try and get back to improving health after lockdown."
M, 61, employed, home owner

What the evidence tells us

[Age UK research on impact of the pandemic on our older population's health]

This study shows that many older people are enduring increased and sometimes devastating levels of anxiety, in part because they know they are at serious risk from the virus – an invisible deadly enemy.

Months of being cooped up at home have led to muscle weakness – 'deconditioning' as clinicians term it - and sometimes a reduced sense of balance, increasing the risk of falls.

In answer to polling questions about how their health had changed since the start of the pandemic:

1 in 3 respondents (**4.2million)** or 34% reported feeling more anxious since the start of the pandemic,

1 in 3 (**4.4million)** or 36% agreed they felt less motivated to do the things they enjoy,

Over a quarter **(3.2 million)** or 26% can't walk as far as they used to,

1 in 5 **(2.4 million)** or 20% are finding it harder to remember things,

1 in 5 **(2.3 million)** or 18% say they feel less steady on their feet,

2 in 3 (7.9million) or 64% felt less confident taking public transport, 2 in 5 **(5.3 million)** or 43% felt less confident going to the shops or 1 in 4 **(3.3million)** or 26% felt less confident spending time with family.

Support for older people during the pandemic

The implementation of the **Enhanced Health in Care Homes** service was accelerated to support care home residents and staff during the COVID-19 pandemic. Building on the commitment in the NHS Long Term Plan to support people living in care homes, collaborative working between health, social care, voluntary, community, and social enterprise (VCSE) sector and care home partners resulted in;

- every care home aligned to a named Primary Care Network with a named clinical lead
- Weekly ‘check in’ – primarily remotely, and usually by a multi-disciplinary team, to review high priority patients
- Development of personalised care and support plans for care home residents.
- pharmacy and medication support – including medication reviews, and support with supply.

These contractual requirements for Primary Care Networks were fully implemented from 1 October 2020, with preparatory requirements completed by 31 July 2020.

NHS COVID19 vaccination programme

More than two million top up COVID-19 jabs have been delivered in just three weeks, as the NHS COVID-19 vaccination programme continues to protect those most at risk from coronavirus. (10 October 21)

Currently, around four million people in England are eligible for a booster including health and care workers, those with underlying health conditions and people aged 50 and over.

The NHS delivered the world's first COVID vaccination outside of a clinical trial to 90 year old Margaret Keenan in Coventry on Tuesday 8 December 2020

Discharge to assess

Imagine leaving your home abruptly and never returning to it again. Imagine being told that you are moving house tomorrow and you have no control over where you are moving to and how much it will cost. **This happened to people prior to March 2020, every day because their assessments for long-term care** took place outside their normal environment.

The Discharge to Assess policy is based on the need for people to have **time to recover** before decisions about ongoing care and support needs are made. This time to recover is critical to:

- ensure assessments do not happen in acute environments, minimising length of stay in hospital;
- prevent over prescription of care
- decrease long term care packages/costs (social care and NHS) through better rehabilitation;
- improve outcomes for people (autonomy and function).

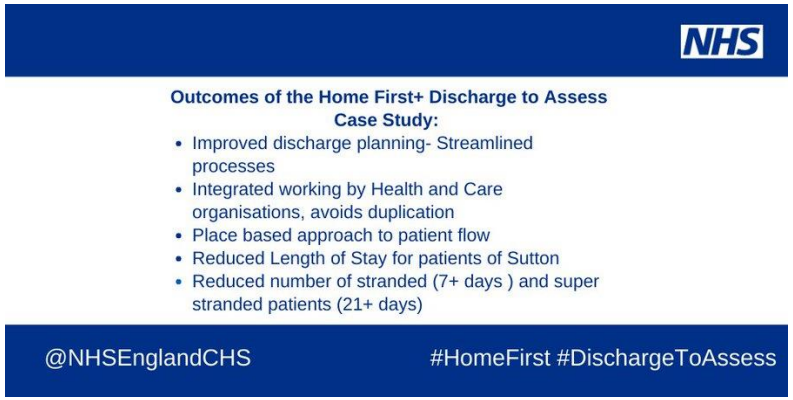
Better outcomes for people
When people spend less time in hospital there is a reduction in deconditioning (muscle wastage) and hospital acquired infections, as well as psychological benefit of reduced risk of depression

With the focus now on reablement at home to regain confidence and skills, there is a promotion of independence, a reduction in long-term care needs and less risk of overprescribing of care

With time to recover at home, people and their families/carers are supported through the initial post-discharge period and given time to consider realistic long-term care and support options.

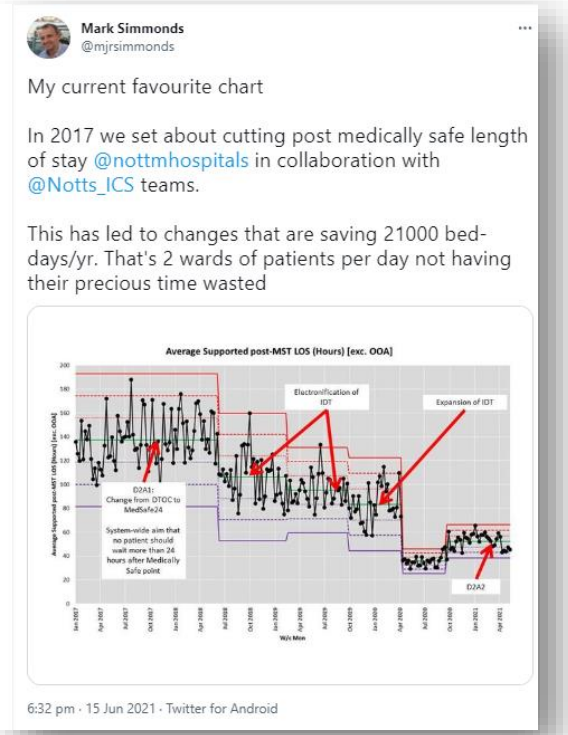
A positive impact across the country

The #DischargeToAssess Home First+ service brings together GPs, nurses, therapists, social care and continuing healthcare practitioners into 1 team. They aim to prevent unnecessary hospital admissions, facilitate discharge and provide support after to reduce readmissions.



@NHSEnglandCHS

Find out how Home First+, an integrated approach to patient flow in Sutton, led to reduced length of stay + stranded patients and appropriate care moving i to the community: https://future.nhs.uk/RLHSNN/view?objectID=26384048… 2/2 #HomeFirst #DischargeToAssess @epsom_sthelier @SurreyDownsHC @ECISTNetwork



COVID Oximetry@home

The use of pulse oximetry has been expanded as part of the NHS response to coronavirus.

Since May 2020, **over 500k** pulse oximeters from the national supply have been distributed to CCGs, trusts, care homes and ambulance services to support people at risk from COVID to be safe at home, and get the NHS treatment they need quickly.

The service is usually offered by general practice working alongside community teams. People are provided with a pulse oximeter and supporting information to monitor their oxygen saturation levels at home for up to 14 days, supported by carers and/or family members where appropriate.

Resources for PCNs and professionals are available on the NHS England and NHS Improvement website: NHS England » COVID Oximetry @home

For more information contact england.home@nhs.net

“Boost out-of-hospital care and dissolve the historic divide between primary care and community health services”

2hr crisis response

“Now expanded community health teams will be required under new national standards to provide fast support to people in their own homes as an alternative to hospitalisation, and to ramp up NHS support for people living in care homes.”

Enhanced Health in Care Homes

People living in care homes should expect the same level of support as if they were living in their own home. We will upgrade NHS support to all care home residents who would benefit by 2023/24, with the EHCH model rolled out across the whole country over the coming decade as staffing and funding grows. “

Population health and anticipatory care

“Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.”

Discharge to assess

“The NHS and social care will continue to improve performance at getting people home without unnecessary delay when they are ready to leave hospital, reducing risk of harm to patients from physical and cognitive deconditioning complications.”

The NHS Long Term Plan committed to increase investment in primary medical and community services by **£4.5bn** in real-terms across the five year period.

www.longtermplan.nhs.uk

2hr crisis response

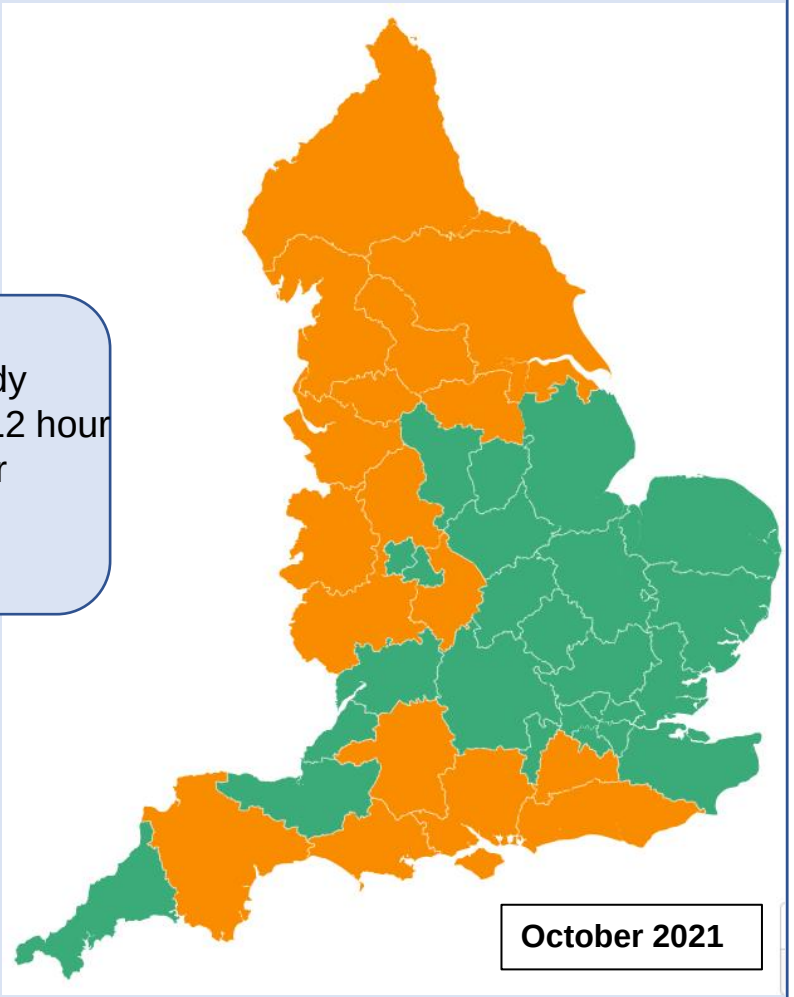
By end March 2022 everyone over the age of 18 in England will have access to a crisis response service within two hours, 8am-8pm, seven days a week.

Guidance on implementing the two-hour standard was published in July 2021.

As a minimum, all ICS planners commissioners and providers must:

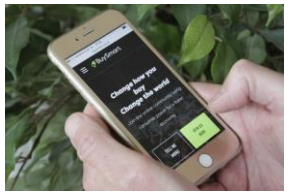
- provide services at scale: to achieve full geographic coverage of two-hour crisis response care across systems
- provide services from 8am- 8pm, 7 days a week
- accept referrals into crisis response services from all appropriate sources and make crisis response services accessible via NHS 111
- submit complete data returns to the Community Services Data Set (CSDS) to demonstrate the achievement of the two-hour standard.

25 ICS areas have already rolled out the 7 day and 12 hour requirements for this year



Current progress on implementing the national standards

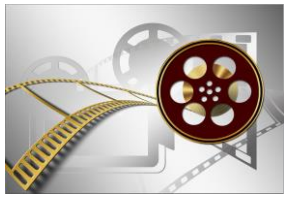
Enhanced Health in Care Homes priorities 2021/22



Care Learning Platform: defining the knowledge and skills a new care worker would need across 4 key clinical areas to support the delivery of EHCH

Roll out of managing deterioration training in care homes: to support care staff to identify and act early on a deteriorating resident by measuring soft signs of deterioration

Evaluation of impact of Multi-Disciplinary Team funding: to understand where further development support may be helpful



Production of animation 'what a good care home round looks like': to support all members of the care home MDT in setting up and running a successful home round

Activities and Impact Dashboard creation: evidencing the impact of full EHCH implementation

Anticipatory Care

New requirements on Primary Care Networks (PCNs) from October 2021 have been substantially scaled back, to recognise the pressures on general practice. New requirements will be introduced in the priority areas of Cardiovascular Disease and Tackling Neighbourhood Health Inequalities, recognising their importance to the recovery of NHS services and inequalities exposed by the pandemic.

New requirements for **Anticipatory Care** and Personalised Care are deferred until April 2022.

All the services are all intended to support a population health management approach whereby PCNs work together to identify their highest need populations and ensures that they receive services which proactively manage their risk, and facilitates better targeting of community based resources.

The Personalised Care and **Anticipatory Care** services both continue the theme of identifying those who at higher need, and ensuring the best targeting of primary and community care based support for those groups.

Future ambitions - frailty Virtual Ward

Aim

- Providing early intervention and proactive support to **reduce hospital conveyances**, **avoidable** admissions, ED visits, and reductions in acute Length of stay through supported discharge.
- Faster, more consistent integrated care across the local system by supporting improved collaboration & coordination of care with **reduced overall cost of care**.

Approach

- Clinically led development of a national clinical model of care through MDT Clinical Reference Group

Digital Discovery to understand how digital, data and technology could improve care delivery

Use of Digital Technology

- The model is not a “Digital First” approach it’s values the hybrid mix and face to face and virtual as appropriate, with a focus on where digital can enable care delivery improving the experience for patients and staff.
- Beyond care delivery effective use of digital, data and technology to support effective service delivery is a key enabler for Virtual Ward and Community Health Services teams

Key Learning

- This is about new services it’s really about new ways of working focused on integration of existing services.
- Digital enablement of virtual wards is already happening, we need to understand where this is working well and help to support others to adopt & adapt for their service

Please get in touch with the team to hear more about the clinical model of care via **email** england.communityhealthservicesorg@nhs.net or directly to jane.sproat@nhs.net

Future ambitions – data extraction

The data on Community Health Services is of paramount importance to understand where, what and how services are being provided and to support the providers in their provision.

NHS Long Term Plan launched new **2-hour** for urgent community response.
These targets are being tracked using data collected via Community Services Data Set (CSDS).

There are **challenges** associated with the **timeliness** of the submissions and the **quality** of the data which result in publishing the data with a 3-month lag. Results of the current collection mechanism and process does not provide enough insight to understand and support the services.

The recent COVID-19 pandemic resulted in growth in waiting lists and increased waiting times for the NHS services. The need for a **real-time view** of the community data has increased to enable service recovery.

Any questions?