

No place like home

Using virtual wards and 'hospital at home' services to tackle the pressures on urgent and emergency care

January 2022

No place like home

What will help to relieve the pressure on hospitals?

- Investment in virtual wards, 'hospital at home' services and social care teams
- A sustainable health and social care workforce.
- A cross-government strategy on health inequalities.

What support do community resource teams need?

- Better regional collaboration and clinical networking across health boards.
- Investment in training more clinicians to work in the community.
- Rapid access to the right diagnostics and interventions.
- Closer working relationships with therapists, social care, and palliative care teams.

It's time to change the way we work

During the second winter of the COVID-19 pandemic, NHS waiting lists are at an all-time high. Hospital emergency departments, primary care and GPs, urgent care and the ambulance service in Wales are all under enormous pressure. Prolonged stay in acute hospitals increases the risk of hospital-acquired infections in older frail patients and disrupts patient flow, an issue that is exacerbated by bed shortages. It is time to think outside the box: radical change is needed.

We're calling for an expansion of the number of virtual wards and 'hospital at home' services that provide specialist medical care in the community across Wales. These teams can help to reduce hospital admissions, get people home more quickly, and improve the quality of patient care.

Wales is getting older

The number of people aged over 65 in Wales is projected to increase by 16.1 % between 2020 and 2030. The increase is even larger in older age groups – the number of those aged over 75 is projected to increase by 23.9% in the same time period.

COVID-19 mortality rates rise sharply with age, and COVID-related hospital admissions have consistently been highest among older people. Yet during the second wave of the pandemic in winter 2020/21, a significant number of people with COVID-19 became infected while in hospital – around two in five of these patients in Wales died, and those with hospital-acquired infection were typically older and more frail than those infected within the community.

Where possible, we need to keep people out of hospital

Many of those who died with probable hospital-acquired COVID-19 had been in the hospital for at least a month prior to exposure. Keeping older people out of hospital and in their own home has never been more important. Over the next few months, the vision of care closer to home as set out in A Healthier Wales must be supported by a significant investment in community resource and staffing, especially in social and intermediate care.

Under pressure: the social care sector in Wales

Darren Hughes, director of the Welsh NHS Confederation, explains why and how the pressures facing the social care sector in Wales impact the NHS.

Problems in the social care system are having serious implications on the ability of doctors to discharge large numbers of medically fit patients from hospital into care packages.

We know that when patients stay in hospital longer than needed, their condition will often deteriorate, they may lose some of their independence, or at best their recovery is hindered. But with a shortage of care packages – whether places in care homes or availability of domiciliary care – often the only short-term option for the patient is to remain in hospital.

Apart from the negative impact on the patient and their recovery, this slows the flow of patients through hospitals, affecting care available for others who need it.

Currently, around 15 % of bed capacity in hospitals is taken up by those unable to be discharged. Therefore, at a time when demand for NHS services is the highest on record, this takes away precious capacity to treat more patients in other parts of the system. One of the most visible knock-on effects is the ambulance service's ability to provide effective and rapid responses in emergencies. If there are fewer beds available inside the hospital because people can't get home without a care package, it's more difficult to treat and admit patients waiting in A&E, which has a knock-on effect on patients arriving by ambulance. Paramedics are then unable to get back out on the road to help more patients. It's all linked.

However, the principal challenge is the shortfall in staff. Many staff working in health and care are exhausted, with wider workforce challenges compounding the situation. Higher absence rates due to stress, psychological issues, needing to self-isolate or due to long COVID, are intensifying pre-existing staffing issues in the system.

This system-wide challenge to provide care is starting to affect the health of our communities, with higher numbers of very sick people presenting in A&E, and compromised quality of life for the thousands awaiting treatment.

Improving this situation requires all parts of health and social care to work together. Hospitals are working hard to improve efficiency in A&E departments, reduce avoidable hospital admissions, especially for frail and older people, and health and local authority partners are taking clear actions to address the undeniable pressure in social care. There is a renewed focus on a broader approach to care and support, including working with primary care, GPs, district nursing and community health teams, the voluntary sector and even families and carers themselves.

The Welsh government needs to urgently provide extra recurrent funding and support to social care services to ensure that medically fit patients can be safely discharged into the community. This will help free up capacity in the NHS, reduce ambulance handover and other delays in A&E, and reduce pressure on community and primary care services.

The full version of this article first appeared in the Western Mail in November 2021 and [can be accessed online here](#).

1. Investment in care closer to home

The long-lasting impact of the COVID-19 pandemic will inevitably place even more pressure on the social care system. The Welsh government must prioritise social care reform, while collaboration between GPs and specialist doctors should be at the forefront of the design and delivery of the care of older people with frailty. Strong professional relationships across primary and secondary care are built on good communication. Intermediate care – including virtual wards and ‘hospital at home’ services – reduces unnecessary hospital admissions and enables people to stay at home for longer.

We need: An ambitious plan to tackle waiting lists and the NHS backlog: not just asking clinicians to ‘do more’, but expanding social care provision and community medicine and supporting patients and the workforce to adopt new technologies to harness innovation and improve resilience.

What are community resource teams?

Community resource teams (CRTs) are made up of health and social care professionals who coordinate care for people living at home. Models vary across Wales: some teams provide intermediate acute healthcare, others are integrated with social care and provide holistic assessment, treatment and support for both short and long-term care. However, CRTs are often under-resourced and under-recognised. During the pandemic, some CRT staff have been redeployed to other parts of the NHS, which has reduced the capacity of community teams to treat patients at home and keep them out of hospital in the first place.

What are virtual wards?

A virtual ward is a multidisciplinary team meeting involving primary care, secondary care, the local authority and voluntary services. The aim is to reduce pressure on unscheduled care by preventing inappropriate hospital admissions and improving flow through hospital by expediting discharge. This is done by providing comprehensive multidisciplinary care in the community. During a virtual ward round, health and care professionals discuss how to support older people with frailty, those with chronic disease and those with increasing social care needs. The aim is to do this within their own community. In addition, virtual wards can improve patient experience, reduce NHS costs and lead to more collaborative working.

What is a ‘hospital at home’ service?

Hospital at home provides short-term, intensive, hospital-level care for acute medical problems in a patient’s home. This is provided by multidisciplinary healthcare teams led by a senior clinician. It can provide urgent access to relevant blood tests, ultrasounds and hospital-level diagnostics and interventions and gives access to the same specialty advice as would be provided for any hospital inpatient. Providing specialist healthcare at home could reduce pressure on NHS resources and be less disruptive to older people with frailty, while leading to higher levels of patient satisfaction.

2. A sustainable health and social care workforce

Specialist doctors, nurse practitioners, nurses, GPs, old age psychiatrists, allied healthcare professionals and researchers provide 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. Where older people are cared for by specialist professionals, their outcomes are better: complex interventions in people with frailty can reduce hospital admission and keep people at home for longer.

This pandemic has taken its toll on our workforce. Health and care staff are exhausted; many are reaching burnout. The NHS needs more specialists in the care of older people; health boards should collaborate in forming a national network for sharing good practice. There is good work happening across Wales, but not enough shared learning between teams.

In the long term, we need to train more health and social care professionals. Over the next 5 years, the Welsh government should double the number of medical school places in Wales to ensure we have enough doctors to meet patient demand in 10–15 years.

We need: A national action plan to develop and retain the current NHS and social care workforce, alongside an increase in medical school numbers and postgraduate training places: targeted at the specialties – such as general internal medicine, geriatric medicine and old age psychiatry – where we will need more health and care professionals to meet patient demand in a decade.

3. A cross-government strategy on health inequalities

The pandemic has highlighted the link between inequality and poorer health outcomes, and it's now vital that we face up to the impact of long-term chronic illness on our society. Older people may be living longer, but 71 % of those aged 65 or older in Wales are living with longstanding illness. Many of the barriers to truly integrated health and social care exist outside the structures of the NHS – expanding the workforce, tackling health inequalities and increasing funding must be achieved through cross-government action, led by the first minister. Meaningful partnership working with the voluntary and community sector and the involvement of patients, families and carers will be crucial.

We need: A cross-government approach to tackle the inequalities that contribute to avoidable illness: not just in physical health, but mental health, housing, education, transport, rural healthcare, digital access, and income, among other social determinants of health.

Community medicine – in real life

Between November 2020 and January 2021, during the height of the second wave of COVID-19, we interviewed health professionals across Wales about their experience of working in the community during a global pandemic. Here they talk about their experiences, reflect on what they've learned, and provide an update one year on.

Meeting the needs of older adults in the community during the pandemic

Dr Priya Fernando is a consultant in geriatric medicine at Aneurin Bevan University Health Board. She leads the Torfaen Community Resource Team (CRT) in south Wales, one of the oldest 'hospital at home' services in the UK, established in 2006.

Our team consists of a consultant geriatrician, specialty doctor, a geriatric trainee registrar and specialist nurses who administer IV treatments, independently review patients, and undertake comprehensive geriatric assessments. Torfaen CRT provides medical care to patients at home, and can administer blood or iron infusions, historically considered secondary care interventions. Additionally, we hold community hospital beds to facilitate direct admission and completely bypass unnecessary acute admissions for frail patients.

We saw a reduction in referral rates at the start of the pandemic in comparison with previous years. However, once the rate of hospital-acquired COVID cases began to rise, CRT referrals gradually increased. Complex and acutely unwell patients who were not suitable for community-based care would refuse hospital admission, as visits from their loved ones were prohibited. We cared for many of our frail patients with COVID-19 in the community and provided information to patients and their relatives to increase their understanding of COVID-19 and its treatment, including intravenous fluids, oral or intravenous antibiotics, and oral steroids. Some patients were assessed and started on home oxygen.

The outcomes of patients with COVID-19 infection, managed in the community under our team, have recently been published. Social and healthcare teams working together, a framework to structure a multidisciplinary approach and an attitude to change our ways of working will be key for better outcomes in future.

I cannot emphasise enough the importance of continuous support and investment. We face so many barriers when we seek extra funding, yet with even limited resources we are still expected to produce significant patient outcomes. Because we are a multidisciplinary team, the money needs to be fairly distributed across health and social care.

The full version of this article first appeared in the RCP's membership magazine, Commentary, in September 2021 and can be accessed online.

'The solution to unscheduled care pressures lies in the community'

The Neath Port Talbot Acute Clinical Team (ACT) aims to improve patient care, prevent avoidable hospital admissions, and expedite discharge from acute hospitals. The team is part of the community resource team (CRT) and works closely with GPs and other health and social care professionals to manage a case load of complex and often acutely unwell patients using a comprehensive geriatric assessment (CGA) model. The service was set up in 2005 and serves a population of about 150,000.

The team is nurse practitioner-led and operates 7 days a week until 10pm. A consultant geriatrician holds clinical responsibility for patients on the case load with support from a colleague 1 day a week. We accept referrals from all health professionals from primary and secondary care and aim to see patients the day they are referred, including weekends. We accept direct referrals from paramedics and have undertaken a successful pilot with the Welsh Ambulance Services NHS Trust (WAST), which enabled us to have direct access to the ambulance stack. This has led to the team undergoing training delivered by WAST in the use of the Physician Triage Assessment and Streaming Service (PTAS).

Our caseload is around 30 patients on any given day. We see about 1,200 new patients every year. The team always goes the extra mile, which is the only way to keep the service going and to meet the increasing demand in the community. During the second wave of the pandemic, the team worked with district nurses, long-term care teams, GPs and volunteers to look after patients in several care homes where the majority of the residents were infected with COVID-19. During this time, we provided specific medical treatments that included oxygen, IV antibiotics and fluids, anticoagulation, steroids, and end-of-life care. This prevented a significant number of inappropriate hospital admissions and provided better care for our patients (poster 713, pp73–74).

Hospitals are firefighting. We have no long-term solution to look after our ageing population, and pressures that once caused a winter crisis have become a year-round problem. We need a national approach to care for older people with frailty – not a sticking plaster exercise that is carried out every winter. The impression seems to be that the answer to unscheduled care is about managing the front door of the hospital and the discharge process. I strongly feel that the solution to unscheduled care pressures lies in the community.

Most most older people with frailty are in the community, especially in our care homes. GPs need support from secondary care specialists and the wider multidisciplinary team to provide the right care to the right person at the right time – but to do this, hospital at home teams need to be adequately resourced. Care home medicine is not simple; it's actually very complex. If our services were scaled up across our health board, we could look after 100–120 patients in the community. That would be equivalent to four or five medical inpatient wards and would have a significant impact on unscheduled care.

'The Welsh government need to make this a priority. It's very frustrating because there's so much rhetoric around improving care in the community, but the resource does not seem to follow.'

One year on ...

Our team had a very difficult time both emotionally and physically during the second wave of COVID-19. Care homes and our communities were badly affected. At one point, we were told that staff would be co-opted into working at the field hospital. We were rushed off our feet and, in the end, we were so busy in the community that moving us to the field hospital would have resulted in a large number of hospital admissions. In some ways, the experience has strengthened the team and reinforced the bonds between us.

Once we have completed our training in PTAS, we hope to gain access to the ambulance stack. This will enable us to take appropriate patients off the stack and prevent a paramedic visit and an admission. But it will take addition resource to undertake this in a consistent manner, while also completing the rest of our work.

Virtual wards are being set up in all our GP clusters and, once established, will be able to provide comprehensive multidisciplinary care to older people with frailty and to those with chronic disease.

Dr Firdaus Adenwalla, consultant geriatrician
Mrs Annette Davies, lead advanced nurse practitioner

Neath Port Talbot Acute Clinical Team
Swansea Bay University Health Board

‘People shouldn’t be admitted to hospital simply because there is no alternative’

The Bridgend Acute Clinical Team (ACT) offers acute medical support and interventions for patients who are clinically stable enough to be treated at home. The ACT also supports older people with frailty who require urgent comprehensive geriatric assessment (CGA), multidisciplinary support or crisis intervention at home. The aim is to improve patient care and avoid hospital admission where possible. Referrals are accepted 365 days a year.

Our clinical practitioners and nurses can organise IV antibiotics, fluid replacement, undertake regular observations and diagnostic tests at home. This can speed up the hospital discharge process or avoid an admission altogether. If a patient deteriorates at home, the ACT can talk through the options and help them decide whether going into hospital is the right choice. An early referral from a GP means we can go out to people’s homes and assess their needs before they reach crisis point.

Our consultant physicians are with us every morning under normal circumstances, and we’ll do a ‘virtual’ ward round. If we need them to go out and see patients, they’ll come with us. This was interrupted by the pandemic because the consultants were working on COVID-19 wards. We used technology to do our virtual ward rounds with them, but it was difficult. For some people in crisis, remote consultation doesn’t work very well. They’re often frail, perhaps with hearing impairments. It’s important that we get out to see those patients in person.

‘People shouldn’t be admitted to hospital simply because there is no alternative. We need more people on the ground; staff who can assess patients and make clinical decisions in the community.’

Our service has proved extremely resilient. We had a major dip in activity during the first wave because we weren’t receiving as many referrals. We kept ourselves busy by supporting district nurses and organising PPE for community services. We swabbed a lot of patients in the community for COVID-19 before a dedicated team was set up. But we are now as busy as we were before the pandemic.

We’ve worked very hard to build our relationships, particularly with GPs. We are also very well-integrated with health and social care; some staff in the team are employed by the health board, while others are employed by the local authority. Others are employed by the health board but funded by the local authority. The organisations locally have worked very closely together. It is more than co-location; it works well because everyone is engaged and signed up to it. I’ve been very lucky with the leadership that we’ve got here. We’re also very good at supporting our staff and helping them to reflect on their practice.

Our data collection is excellent. We can prove that we’re making a real difference: the ACT is estimated to avoid around 3,800 hospital bed days each year.

People shouldn’t be admitted to hospital simply because there is no alternative. We need more people on the ground – staff who can assess patients and make clinical decisions in the community. Ultimately, there is no other way of getting around it: if we’re going to do more work, then we need more staff.

One year on ...

Last winter was very, very challenging. At one point, most of the team was off sick or isolating. I worked 3 weeks of long days over Christmas to keep our existing caseload ticking over. We made a lot of sacrifices. The service didn't collapse, and we didn't send anyone into hospital, but we certainly couldn't take on any new patients.

By February 2021, the unmet need was beginning to kick in again and we were hit with a secondary wave of all those people who had been getting quietly unwell at home. Some of our staff were suffering with fatigue, and were struggling to concentrate. We've been asked to do extra work this winter: new facilities, new pathways. We've agreed to take it on, but the reality is that we don't have any more resources to do this. It's frustrating because we're doing very good-quality work. But when we're busy, our lead time increases, and it can take us up to a week to respond to an urgent case. Our colleagues are generally understanding, but we worry that people will start to lose the faith and stop referring to us.

When our staff numbers are low, hospital admissions rise. I feel like I'm fighting to maintain the service when we should be growing the team, which is frustrating. Hospital services continue to be the rich relation when it comes to prioritising resources.

Our winter plans are fragile. We're tired and under pressure. We need more staff, but when we recruit, we simply take from other existing teams, so it's robbing Peter to pay Paul. We need to train more doctors and nurses. It's only going to get worse.

Thomas Barton, lead advanced nurse practitioner

Acute Clinical Team, Bridgend Community Resource Team
Cwm Taf University Health Board

'Working in community medicine teaches pragmatic decision-making and improves patient-centred care': the trainee perspective

Dr Richard Gilpin is a specialist registrar in geriatric and general medicine in Cardiff and Vale University Health Board. When the pandemic began, he was working in a community resource team in south-east Wales.

Like most geriatric trainees, I completed a 6-month rotation with a community team.

Mine was a unique experience, starting in February 2020 at the start of the pandemic. As a doctor who has always worked within the four walls of a hospital, two aspects of my new role struck me immediately. Firstly, the tests and advice you are used to aren't immediately available – the idea of 'quickly adding on a blood test' is impossible. Secondly, we were very conspicuous. Passers-by would take photographs of us in full PPE entering a patient's house at the start of the pandemic. The role teaches you to rely on clinical acumen, pragmatic decision-making and patient-centred care.

I certainly dealt with a greater number of critically unwell patients than the team would usually manage because of the pandemic. Many patients and families were scared that hospitalisation would result in harm from COVID-19 – which was a real possibility at the time.

When a frail patient is admitted via the emergency department, we ask a list of questions about their function and social circumstances. The doctor will end up with a superficial idea of how the patient is at home, with understandable errors and omissions. It is impossible to deliver the care we would wish to deliver when the patient is in a hospital gown and on a hospital trolley at 2am.



However, you can instantly understand a patient's lifestyle when you are in their home. We saw one patient following two admissions with diarrhoea and a normal CT scan and colonoscopy. Her symptoms would improve in hospital and she would be discharged. Her fridge had out-of-date and rotting food in it, and we fixed her diarrhoea by sorting out her meals. For many patients, a comprehensive review in the community would have been the only way to truly understand the underlying issues.

Strangely, although I expected to feel isolated, this was far from the reality. Managing a caseload of up to 30 patients via a 'virtual ward' required regular and detailed conversation through morning board rounds, afternoon catch-ups and close liaison throughout the day. Although I am indebted to the senior doctors for their guidance and support, I learned most from the dedicated and enthusiastic nurse practitioners, who brought together their experience and clinical knowledge with clear, pragmatic decision-making.

A successful community resource team relies on several factors: the right staff, rapid access to the right diagnostics and interventions, and the right education and training.

'The crucial thing is building those relationships, especially with social care'

The North Denbighshire Enhanced Care Service (ECS) works with GP practices to deliver enhanced care to a population of around 59,000 in north Wales. The multidisciplinary, multi-agency team provides 'step-up' (patients admitted to ECS by GPs) and 'step-down' (patients discharged early from acute and community hospitals) care to individuals with increased medical needs in their own homes.

Ours was the first service of its kind in north Wales. The team is made up of nurse practitioners, a physiotherapist, an occupational therapist, a social worker and healthcare support workers, supported by an administrator. We sit in the community resource team: patients remain under the care of their GP, and a consultant geriatrician from Ysbyty Glan Clwyd is directly available for advice and to assess patients at home when required.

It's a very broad, multidisciplinary, multi-agency team that treats around 285 patients a year, 95 % of whom are stepped-up to prevent hospital admission. We estimate that this saves more than 3,000 acute hospital bed days annually. The team meets virtually now; remote working has allowed more people from across health, social care and the third sector to be involved, which is great. We consider ourselves a 'virtual ward'. Patients are at home, but we can request urgent diagnostics: CT scans, ultrasounds, blood tests and so on. We can also pull in expertise from other specialties, including respiratory medicine, psychiatry and palliative care.

'The whole team works well – we get things done. The crucial thing is building those relationships, especially with social care.'

Unfortunately, due to the pandemic, our social care colleagues are all working from home. We miss the day-to-day interaction with social care – it can be very frustrating. Many of us have looked at our working practice and considered how to use our time and resources more efficiently. As clinicians, we've quickly learned how to make clinical judgements based on virtual technology. It was a steep learning curve.

Initially we struggled to access PPE and community testing for COVID-19. The emphasis was very much on the acute hospital setting. It took a long time for people to realise that patients on the virtual ward should have the same access to tests as inpatients. Now we have COVID-19 patients receiving step-down care following discharge from hospital. It has been challenging, but the healthcare staff who go into people's homes have done an incredibly brave job.

Our therapy teams have been under-staffed in the community for some time. We're covering a big geographical area and we can't give patients the intensive service they would receive if they were in a hospital. Despite all the challenges, the team still provides remarkable care. We won a health board achievement award in 2016 for quality in primary care, and we get so much positive feedback from patients and families. We're a close team – we really do support each other.

One year on ...

The North Denbighshire ECS is as busy as ever. We are doing our best to accommodate 'step-up' patients from GPs to avoid hospital emergency department attendance. At the same time, we are 'pulling' patients from the acute inpatient wards to create space at Ysbyty Glan Clwyd, which is under relentless pressure.

The number of people at our virtual rounds has increased – some of us meet face-to-face in the 'hub' with the others joining virtually including a pharmacist from a large GP practice. We have had more social services colleagues contributing to the discussions, though there have been immense challenges in obtaining timely care packages due to workforce gaps in the care sector. Our South Denbighshire ECS colleagues now also join us to access consultant geriatrician advice on the complex cases.

Given the rising prevalence of frailty and complex co-morbidities in an ageing population in our patch, prompt access to diagnostic, therapeutic, rehabilitative and palliative interventions at the patient's home is likely to be the way forward to reduce demand in hospital, while at the same time offering better patient experience in a clinically safe and effective manner.

Dr Indrajit Chatterjee (Chattopadhyay),
consultant physician
Nicola Bone, physiotherapist
Sarah Wickerson, occupational therapist
Phil Rathbone, advanced nurse practitioner
North Denbighshire Enhanced Care Service
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'Without seeing patients face-to-face, it's difficult to know the impact of their illness'

The Caerphilly Falls and Bone Health Service was established in 2012. The team runs face-to-face clinics at Ysbyty Ystrad Fawr and in the community, a multidisciplinary falls service through the local community resource team and a virtual bone health clinic for the wider area.

We've been running virtual bone health clinics since 2018. We've improved the way we treat patients with a higher risk of fractures, such as those with Parkinson's disease and osteoporosis, and we've worked with GPs to identify at-risk patients at an earlier stage. We won an NHS Wales Award for demonstrating significant service improvement and promoting clinical research, and since 2016 we've worked with the Royal Osteoporosis Society (ROS) to develop new initiatives, improve patient communications, and deliver staff training.

Along with the district nursing team, GP surgeries and the community resource team, we aim to provide seamless care between the hospital and the community. We review shared care plans annually for those on specialist treatment to support our colleagues in primary care. When we receive a referral, we always write back to the GP to acknowledge their letter and outline our plan of action. Administrative support is crucial, as this is how we make sure the service is patient-centred. It is vital that we communicate key messages about osteoporosis to people without overwhelming them with too much information.

I won't say that COVID-19 hasn't affected us, but we were running virtual bone health clinics and telephone appointments long before the pandemic. In response to COVID-19, we increased the number of our telephone clinics every week and completed over 500 consultations. We have also proactively reached out to GPs to offer remote support in managing bone health in the community to reduce unnecessary hospital admissions.

Having these services in place has really helped during the pandemic. We started out simply wanting to improve patient care, but when COVID-19 came along we felt lucky that we were well-prepared. It's still a struggle, though. Without seeing patients face to face, it's difficult to know the psychological impact of their illness. It's hard to assess their loneliness, their fear and their cognitive function. We can't do that on the phone, and we're going to see the impact of COVID-19 on other services sooner rather than later.

There are things we could change. We still don't have a good enough relationship with our local authorities, and I'd like to improve our communication with them.

‘There is no network of intermediate care services in Wales; there’s not enough shared learning between health boards.’

In the future, we’d like to provide more specialist support to our colleagues in primary care by running clinics in GP surgeries. We’d also like to develop our virtual bone health clinics so that families and carers can become more involved. Finally, we would like a falls and bone health specialist nurse. A senior nurse would provide a strategic lead for the service, as well as improving patient communication and data gathering.

One year on...

In the past year, we have appointed two specialist nurses. We’ve also expanded our virtual bone health clinics, improved our data collection, and introduced a new set of six ROS standards to manage and improve osteoporosis and fragility fracture care in the community. We feel well-prepared for winter.

We’ve had a tough year, though. COVID-19 hit us very badly. But, at the same time, the pandemic has made me think differently. It has given us new opportunities. Virtual working has saved time and resources. It has improved communication with patients and families. It has allowed me to spend more time teaching doctors in training. Our relationship with primary care has improved, which means we are reaching more patients who are at risk.

In the longer term, I’d like to see bone health nurse specialists in every health board, with every service following the ROS standards, and much more networking across Wales.

Dr Inderpal Singh, consultant physician
Dr Anser Anwar, specialty doctor
Mrs Jane Power, medical secretary and administrative officer

Caerphilly Falls and Bone Health Service
Aneurin Bevan University Health Board

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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 4,500 members, including more than 200 in Wales. We are the only society in the UK offering specialist expertise in the wide range of healthcare needs of older people.

www.bgs.org.uk/
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