

Building the 'New Normal': Harnessing transformative practices from the COVID-19 pandemic

IHF 'Beyond COVID-19' Task Force



International
Hospital
Federation

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EXECUTIVE SUMMARY

Acting as a radical disruptor to the 'normal' way of doing things, the COVID-19 pandemic has accelerated transformations within healthcare delivery at an unprecedented pace. In many instances, these changes have incorporated a fundamental redesign of service delivery, with profound implications for both staff and patients. Though the primary catalyst for change has been the urgent need for infection control, it is notable that some transformations have been long-standing priorities for healthcare systems, on which limited progress was made prior to the pandemic. The coronavirus crisis has provided a new context for how healthcare should be delivered.

Drawing directly of the experiences of the IHF 'Beyond COVID-19' Task Force and their networks, this paper offers insights into how hospitals can embrace new ways of delivering healthcare: ['Building the 'New Normal': Harnessing Transformative Practices from the COVID-19 Pandemic'](#).

In what ways have hospitals transformed?

Outlined below are a flavour of transformations realised during the COVID-19 pandemic. Some of these changes are not new ideas but the coronavirus crisis has acted as a catalyst for their widespread acceleration and adoption.

Harnessing digital technology to provide care

In relation to healthcare delivery, one of the biggest 'service shifts' in the sector has been widespread adoption of telehealth and telemedicine. Given the high risk of transmission of coronavirus through person-to-person contact, the pandemic has accelerated an unprecedented global expansion in telehealth. The Task Force found that telehealth models have been implemented in three primary ways: the large-scale screening of patients prior to hospital visits and triage assessment; in the routine [provision of care at home](#), and also in the [remote monitoring patients by off-site specialists](#).

Revolutionising hospital infrastructure

Hospitals have re-examined how their physical environments and technical infrastructures can be adapted to enable greater flexibility when responding to events which generate temporary, yet [sizeable surges for services](#). In relation to supply and infrastructure, the IHF Task Force found that healthcare organisations and hospitals took three principal approaches to make lasting changes to their environments in response to COVID-19: reorganisation of the health service facility itself; creation of emergency structures; [conversion of existing non-health structures](#).

Digitising person-centred communication

Spending time in hospital can be an anxious experience, even more so during a challenging pandemic: communication is vital to the mental wellbeing of patients. On the agenda of 'people, the Task Force found many hospitals have reformed traditional ways to communicate during the pandemic when the usual ways of interacting were not possible. In particular, [virtual visiting](#) will continue as a mainstay for families and patients to keep in touch beyond the immediate pandemic.

Moving beyond COVID-19

As hospitals enter their recovery phase post-COVID-19 and start to address the backlog of care and unmet need caused by the pandemic, they will need to maintain openness to radical innovation and learn from what made such a response possible. The need to improvise and adapt will continue for the foreseeable future; ensuring that when the next public health crisis hits, hospitals are prepared. The IHF remains committed to supporting its global community meet this challenge.

ABOUT THIS REPORT

Supporting hospitals in a time of crisis

The COVID-19 pandemic has united healthcare systems across the world with a common purpose: ensuring capacity to help those who have been affected by coronavirus and minimising its impact on the health and well-being of people and their communities.

Never have hospitals and healthcare organisations been forced to change so radically in such a short period of time. COVID-19 has acted as a radical disruptor to the 'normal' way of doing things, accelerating transformations within healthcare at an unprecedented pace. We have seen critical care services being run virtually using digital technologies; organisations rapidly up-skilling staff and mobilising volunteer carers at scale; the breaking-down of workplace silos to ensure patients receive integrated care; creative architectural solutions to manage flows of people in and out of hospitals as part of infection control.

These changes have, in many instances, incorporated a fundamental redesign of services, with profound implications for both staff and patients. Although the primary catalyst for change has been the urgent need for COVID-19 infection control, it is notable that some of these have long been priorities for healthcare systems, on which there had been limited progress prior to the pandemic. The pandemic has provided a new context that allowed previously long-held assumptions and norms about how care should be delivered to be urgently re-examined and, if necessary, changed. To support its community to realise the benefits of these changes, the International Hospital Federation established the [IHF 'Beyond COVID-19' Task Force](#).

Comprising IHF members and strategic partners from across the international healthcare community, the Task Force was charged with supporting hospitals to adopt practices realised during the COVID-19 pandemic, which have beneficially transformed healthcare services and so should be sustained in the future. Drawing directly of the experiences of Task Force members and their networks, this report offers a series of insights – accompanied by a selection of case studies - documenting how hospitals can embrace new ways of delivering healthcare, whilst responding to the evolving coronavirus pandemic.

Who should read this report?

This report is written primarily for hospital leaders and clinicians, engaged in both executive and/or operational dimensions of healthcare. This report has been written against the backdrop of the biggest global public health crisis in a generation. The ability of healthcare systems to respond to and recover from this unprecedented crisis will vary significantly, and it is not intended that this report be definitive in its scope, rather offering a snapshot of activities and overarching recommendations.

1. MAINSTREAMING OF TELEHEALTH AND TELEMEDICINE

What was the transformation?

One of the biggest 'service shifts' in the healthcare sector since the onset of the COVID-19 crisis has been the widespread adoption of telehealth and telemedicine. Given the high risk of transmission of coronavirus through person-to-person contact, the pandemic has accelerated an unprecedented expansion in telehealth and telemedicine around the world. Telehealth models have been implemented in three principal ways: the large-scale screening of patients prior to hospital visits and triage assessment; in the routine monitoring of patients at home, for remote clinical encounters, and also supervising patient care by off-site specialists.

Synchronous telehealth (where the use of audio-visual technology to enables clinicians and patients to communicate in real-time) has become a particularly valuable option for **providing continuity in care and treatment** during the COVID-19 pandemic. Telehealth enables clinicians to provide routine consultations via video and monitor clinical signs of certain conditions remotely (i.e., blood pressure) through healthcare 'wearables'. This minimises disruptions to patients' care plans and treatment and reduces the risk of coronavirus contraction by eliminating travel to a clinical setting for care – something particularly beneficial for vulnerable patient groups, such as the elderly or those with co-morbidities.

Synchronous telehealth is also **well-positioned to help healthcare systems combat professional staffing shortages**. Globally, the coronavirus pandemic has exacerbated shortfalls in the healthcare workforce – in particular, a lack of specialist staff to manage intensive care units (ICU). Leveraging telehealth technologies enables hospitals to optimise their clinical capacities. In using remote patient monitoring, one specialist can monitor multiple patients at a time, across different sites. Less time is spent moving physically between patients and thus, a clinician can increase the number of people who can be treated. In turn, this can reduce wait times for appointments, and at least partially, offset workforce shortages caused by COVID-19.

Examples of where telehealth has been employed in response to COVID-19, to transform healthcare delivery include:

- [Gillette Children's Specialty Healthcare Centre \(United States\)](#), whose Rehabilitation Department adopted a virtual service model to provide continuity of care and treatment for children and young people.
- [Apollo Hospital Group \(India\)](#), who leveraged telehealth to scale up its hospitals' capacity to remotely monitor patients in intensive care units.
- [Alder Hey Children's NHS Foundation Trust and Liverpool Women's Hospital \(United Kingdom\)](#), who launched a telemedicine service to protect neonates from contracting COVID-19 whilst continuing to care for Patients who required monitoring and/or urgent clinical opinions.

Key Learnings

Innovative digital health solutions can help mitigate the impact of COVID-19 in critical care settings. As well as being a viable option to provide continuity of care and treatment to patients, telehealth has helped transformed how health systems response to chronic workforce shortages.

However, to implement telehealth effectively, hospitals must invest in appropriate technological infrastructure and staff training. The openness of staff to embrace and employ new digital tools is paramount to their successful adoption. Moreover, it is critical that patients are well-supported to obtain and navigate telehealth technologies to ensure their broader uptake and to prevent inequities in care access. With the exception of a physical examination, care quality standards of telehealth and telemedicine should be the same or no lesser than in-person care; the care process must not be compromised in way which jeopardizes patient safety.

Long-term, the ability to link integrate telemedicine data with electronic health records for improved clinical decision-making, as well as the ability to provide patients access to their preferred providers, will be important markers of telehealth's success.

Transformation Checklist:

- Digital health infrastructure is key to the successful roll-out of telehealth and telemedicine.
- Staff training programs to ensure clinical standards of care are maintained.
- Support for patients to take-up new digital models of care, particularly vulnerable or elderly groups.

2. REVOLUTIONISING HEALTHCARE INFRASTRUCTURE

What was the transformation?

As the coronavirus crisis has revealed, many modern hospitals and healthcare organisations **lack the flexibility to accommodate sudden surges of patients** due to unexpected public health events. Since the onset of the coronavirus crisis, hospitals have been running out of space and resources to treat COVID-19 patients with severe symptoms, whilst simultaneously caring for those groups presenting mild symptoms or being asymptomatic, who pose an infectious risk to healthcare workers and other patients.

To meet this challenge, healthcare architects **identified new design opportunities** for hospitals - which have historically been constructed to support lean and efficient care operations, with a focus on delivering health services closer to patients' homes, within community settings. Healthcare organisations and hospitals took three principal approaches when transforming their environments in response to COVID-19.

1. *Reorganisation of the healthcare facility itself*

To better accommodate COVID-19 patients, many hospitals undertook spatial and organisational adaptations to separate patients infected by coronavirus, from those without the virus. Typically, this has involved the reorganisation of internal 'foot traffic' routes for healthcare workers and patients, as well as the establishment of compartmentalised 'zones of risk' – as demonstrated in Argentina (Box 1) and Taiwan with [Taipei City Hospital's 'Traffic Control Building' model of disease containment](#).

Box 1: Rosario General Directorate of Hospital Architecture & Engineering and Ministry of Public Health (Argentina)

In Argentina, the municipality of Rosario's General Directorate of Hospital Architecture and Engineering worked in collaboration with its Ministry of Public Health to harness the built environment of hospitals as a way to protect patients and healthcare workers from COVID-19. Across the municipality, over 50 public and private healthcare centres and hospitals adopted a joint strategy to differentiate routes within their internal environments for patients who presented symptoms of COVID-19 from those with non-coronavirus needs. Using colourful signage and special demarcations on floors, patients displaying symptoms of coronavirus are directed along interior routes to dedicated testing clinics near the entrance of each centre, to minimise the flow of people into the hospital and thus reducing the risk of nosocomial infection.

The COVID-19 pandemic has also exposed a new **trend for contactless technologies to support environmental infection control**. Hospital designers and architects have identified the need for touch-free control for lighting, temperature, and other building functions, to avoid spreading diseases on these highly used surfaces. For example, at the onset of the pandemic, Guatemala's Hospital Nacional Especializado de Villa Nueva transformed all of its bathroom facilities for staff and patients to include hands-free washing facilities, operated by a sensor. This design modification has helped reduce the immediate risk of COVID-19 contamination and will be adopted as 'standard practice' in future building projects by the hospital.

Another emerging trend in environmental infection control includes furnishing interior spaces with materials which are less hospitable to microbes, thus lowering risks of surface transmission. At M Health Fairview Bethesda Hospital (United States), soft and porous materials which are difficult to disinfect (i.e., carpets) were replaced with hard and non-porous surfaces (i.e., plastic) with minimal joints, as part of the organisation's lasting environmental response to COVID-19. In a similar fashion, some hospitals have eliminated window curtains, which can become easily contaminated, by installing windows made of 'smart' privacy glass which can switch between translucent and opaque settings and has an easier cleanability.

2. *Creating emergency temporary structures*

In addition to internal changes in the hospital, many emergency structures have been created externally by healthcare organisations to maximise space across their campuses. A large number of hospitals have installed prefabricated modules (containers, shelters, or new modules) designed and modified to respond to the needs of the COVID-19 emergency – primarily with the purpose of facilitating expansion of diagnostic testing for coronavirus. For example, at [Taipei City Hospital \(Taiwan\)](#), outdoor hard-sided tents were set-up across each of the organisation's eight entry points to screen patients for COVID-19 symptoms, prior to hospital admission. Whilst temporary structures were first proposed as a barrier for the initial and preliminary approach of patients with suspected coronavirus, such structures can be readily deployed in the case of future public health emergencies and for many hospitals, represented a novel way of triaging patients prior to their admission.

3. *Converting existing non-health structures*

Some healthcare organisations opted to dedicate entire buildings to COVID-19 patient care and so redeveloped non-health areas within their campuses (such as staff gyms and storage units) which were either underused or abandoned. In [Saudi Arabia, the King Faisal Specialist Hospital & Research Center established a 'drive through pharmacy'](#) in a previously unused mobile unit, located in the hospital's carpark. This pharmacy has helped to ensure that vulnerable patients with chronic illnesses no longer have to enter the hospital to receive their medication, reducing the risk of person-

to-person COVID-19 infection. This model of service delivery will continue to be utilised after the coronavirus pandemic has subsided.

Other hospitals looked beyond their own campuses to convert non-health structures. Typically, the Task Force found that ‘urban containers’, such as exhibition centres, conference centres or railway stations – have been harnessed by centres for patient care as demonstrated by NHS England (United Kingdom) (Box 2).

Box 2: NHS England (United Kingdom)

In the United Kingdom, the National Health Service built several major field hospitals to specifically treat COVID-19 patients and ease pressures on regional healthcare services. One of these hospitals – NHS Nightingale London – was established in the capital’s ExCeL exhibition centre, creating space for up to 4,000 patient beds. The framework for individual bed bays were made from material usually used to make exhibition stands due to its lightweight design and could be constructed quickly. The ExCeL’s existing electrical infrastructure was modified to ensure the power supply can cope with demand, whilst temporary generators and oxygen tanks, to supply the beds, have also been installed.

When converting non-health structures into patient centres, it is crucial that location be considered as a key factor (for supplies and staff). Indeed, the ExCeL centre’s suitability for the hospital site goes beyond the functional characteristics of the building as it is served by public transport links. The nearby London City Airport can be used to bring in supplies and equipment and there is much hotel and university accommodation close by - should it be needed.

Key Learnings

Going forward, hospitals will have to examine how their physical environments and technical infrastructures should be adapted to enable greater flexibility when responding to exceptional public health events which generate temporary, yet sizeable demand surges for healthcare services.

To be able to respond effectively to public health events in the future, hospitals should build on their infrastructure transformations realised during the COVID-19 pandemic and work in partnership with local experts – such as environmental agencies, infection prevention experts, engineers, and architecture groups – to develop a ‘compartmentalisation plan: in which ‘safe’ areas can be readily converted during times of crisis (be these internal or external to the hospital). For example, patients with COVID-19 should ideally be placed in private rooms as the virus is highly contagious. A flexible hospital design would allow for typical treatment bays to be converted into single-patient rooms for treating respiratory infection. Such rooms could be created by permanent ceiling mounted tracks that accommodate temporary fabric partitions or curtains.

Transformation Checklist:

- Access to experts with experience in healthcare design and architecture; engineering and construction; infection control and environmental services.
- An up-to-date survey of the hospital’s infrastructure capabilities.
- A champion with executive agency to relax local regulations, allowing alternative patient care facilities to be implemented in times of need.

3. DIGITISING PERSON-CENTRED COMMUNICATION

What was the transformation?

Many hospitals have put in place strict control measures to protect patients, families, and staff from the risk of coronavirus infection. With these restrictions, relatives and carers of patients can no longer make in-person visits, and so healthcare workers become the primary link between patients and their families. For hospital staff, especially those working within intensive care units, visiting restrictions can create greater difficulties in keeping families and carers informed about a patient's progress, included in decision about treatment options, etc.

The need for social distancing to prevent transmission of coronavirus is well understood, but a humane approach to visiting policies in hospitals need not be incompatible with an effective pandemic response. Spending time in hospital can be an anxious experience, even more so during a challenging pandemic: communication is vital to the mental wellbeing of patients. During the COVID-19 crisis, many hospitals have harnessed digital technology to combat the loneliness and social isolation felt by patients by being away from families and carers. In a University Hospital Trust in Cambridgeshire (United Kingdom), [one of the new ways of helping COVID-19 patients communicate virtually with their relatives included a 'Relatives Communications' Team](#), whose mandate involved arrangements for 'virtual visiting' enabling families and patients to communicate whilst being physically apart.

Key Learnings

Virtual visiting has many merits for being sustained beyond the immediate COVID-19 pandemic. It provides an optimal solution for patients to connect with their families and carers regardless of geography and can engage multiple parties at the same time - which is not always possible with standard hospital visiting protocols.

Moreover, virtual visiting has also proved useful in gauging cognitive and physical function and assessing a patient's progress with rehabilitation. Indeed, in the case of [Queen Elizabeth University Hospital \(United Kingdom\)](#), allied healthcare professional staff have held joint sessions with a patient's relatives via an in order to facilitate their discharge. These healthcare professionals have documented that patients are increasingly motivated to progress to discharge when their families are connected digitally to a session.

Transformation Checklist

- Access to digital infrastructure – smart phones, tablets, or laptops – is critical to ensuring two-way communication between patients and their relatives.
- Support and training for patients and their families – particularly the vulnerable or elderly - to use new forms of communication (e.g., video calling).
- A central administrator to plan and coordinate communication sessions between patients and their families or carers.

4. UPTAKE OF RAPID INFORMATION EXCHANGE

What was the transformation?

Many healthcare systems have experienced historic difficulties in exchanging information at the micro and macro-level: from devices to departments, from department to department, from hospital to hospital. When healthcare information is not readily available and actionable, patient care can be impacted – for example, patients can end up staying in intensive care units longer than necessary, resulting in overcrowding or exposure to clinical errors. To ensure a successful response to a pandemic, it is crucial that healthcare professionals have readily available access to real-time information about patients (such as, travel history or occupation) to support clinical decisions. COVID-19 has acted as a catalyst for initiatives (at the micro and macro level) which promote rapid information sharing, overcome bureaucratic ‘red tape’ and improve interoperability across different systems.

As outlined in Box 3, Taiwan’s innovative integration of the country’s electronic health records system with immigration data enabled the country’s targeted response to COVID-19. Although the system was not initially designed to stop a pandemic, it was nimble enough to be reoriented toward one.

Box 3: National Health Insurance Association (Taiwan)

Taiwan has experienced very low numbers of COVID-19 cases and deaths. One of the key factors in this success is the innovative use of information sharing as a tool for pandemic control. Ahead of Taiwan’s first COVID-19 case, the country’s National Health Insurance Association developed a centralised real-time alerts system for potential cases of coronavirus by linking MediCloud – a system which provides healthcare organisations and patients with real-time access to health records - with border entry and exit data uploaded from Taiwan’s National Immigration Agency. These automatic system alerts allow healthcare providers to obtain patients’ travel history, high-risk occupation, contact history, and clustering at mass gatherings in real-time, enabling a more efficient triage and accurate diagnosis of COVID-19. This enhancement to the MediCloud system has been vital to Taiwan’s precision testing strategy, which is efficient in testing a small but critical number of people, instead of mass-testing.

Key Learnings

The coronavirus crisis has emphasised the need for robust digital infrastructures to support high-quality, bi-directional information exchange. This ability has the potential to improve the clinical decision-making process across a hospital’s care continuum by providing healthcare professionals with access to the right data, at the right place, and the right time.

Transformation Checklist

- A central catalogue of routine data collections which can be shared with local stakeholders.
- A robust strategy to ensure that information is collected, stored, and shared in standard ways that allow it to be exchanged readily with third parties.
- An internal organisation focal point to ensure that only ‘one version of the truth’ is being shared in information exchanges with external partners

5. AGILE PROCUREMENT AND SUPPLY MANAGEMENT

What was the transformation?

Since the onset of the COVID-19 pandemic, procurement and supply chain management groups in the healthcare sector have faced unprecedented challenges: from shortages of commonly used medical supplies and drugs to quickly pivoting the distribution of different therapies as new clinical guidelines have emerged on the most effective coronavirus treatments. In particular, the healthcare sector has experienced exponential growth in demand for intensive care products and personal protective equipment (PPE) - putting even basic healthcare assistance for COVID-19 at risk. As the worldwide PPE demand surged, it surpassed global production capacity (also affected by supply disruptions in the People's Republic of China, the leading producer of PPE). This dramatic rise in depleted stockpiles, both from hospital and traditional suppliers, prompted exorbitant price increases, and led to production backlogs in fulfilling orders. The most significant challenge for hospitals was to ensure that critical PPE products were sourced and allocated to frontline health workers, especially those most vulnerable to the spread of the coronavirus.

As the COVID-19 pandemic disrupted traditional supply chains, **hospitals have had to consider 'out of the box' providers and diversify their suppliers** – not only in terms of industry (Box 4) but also from a geographic perspective to reduce supply risks from any one country or region. This is particularly important for items, such as PPEs, where there is historical a limited market of suppliers.

Box 4: St Luke's Boise Medical Center (United States)

At the onset of the coronavirus pandemic St Luke's Medical Center (US) experienced difficulties with the supply and inventory of PPE - in particular, a substantial increase in the rate of consumption of surgical N95 masks across the organisation. As demand began to outstrip supply, St Luke's conducted an analysis to identify alternative sources of mask supplies and new supply chain routes. To obtain PPE, supply chain leaders at St Luke's tapped into domestic dental, veterinary, hospitality, pharmaceutical laboratories, and tattoo distribution channels to obtain approximately six to 11 months' worth of PPE.

The challenge to find adequate personal protective equipment has exposed the inherent risks of inventory and single-sourcing models, driven exclusively by cost control across all levels of the healthcare sector. In this situation, hospitals and healthcare organisations may end up competing (out of necessity) in complex, volatile market conditions for medical equipment or drugs, resulting in differences in the quality of supply purchased and therefore, inequalities in patient care. In order to build agile procurement systems and resilient supply chains, it may be necessary for hospitals to come together and build 'economies of scale'. For example, during the COVID-19 outbreak, RESAH was mandated by the French Ministry of Health to support and optimise the distribution of PPE equipment from the central national warehouse to the different healthcare organisations in France (Box 5).

Box 5: Réseau des Acheteurs Hospitaliers (RESAH) (France)

RESAH is a Group Purchasing Organisation in France, working with hospitals and healthcare organisations across the country. During the COVID-19 pandemic, one of the main reported problems to RESAH was the lack of coordination for the procurement of PPE and COVID-19 related products at local, regional, and national levels in France. Instead of working together as an 'economy of scale', many hospitals went in direct competition against one another to the market, which generated price surges.

In order to avoid this situation in the future, the French state has created a national consortium for the procurement and the delivery of critical PPE. This consortium is composed of RESAH and another national public central purchasing body, specializing in the healthcare sector (UniHA), and La Poste, the national public mail service. RESAH and UniHA are conjointly in charge of the procurement of PPE. An online platform between the three organisations has been developed to allow any French healthcare organisation to buy PPE on it. La Poste oversees the stocking and delivery of the products directly to the healthcare buyer.

Key Learnings

A main focus of the coronavirus pandemic has been the need for PPE and IC therapeutics.

Shortages of these products have seen an increase in costs, and for healthcare organisations to source non-traditional suppliers to fulfil their supply needs. Shifting hospital purchasing and supply chains towards more reliance on local suppliers not only reduces geographical risk in sourcing but can also bring environmental benefits and making selling and delivering products much easier, by eliminating the need for intermediaries.

Transformation Checklist frequent

- Agreed protocol to process periodic inventories of hospital supplies to ensure sufficient 'buffer' stocks are in place for future unexpected healthcare crises.
- A database of consumables and equipment manufacturers critical in a pandemic, to better track and allocate limited resources across different departments and sites.
- Collaboration between supply chain partners is paramount for assuring an adequate supply of medication, devices, etc. during a public health event.

BEYOND COVID-19: BUILDING THE NEW 'NORMAL'

The COVID-19 pandemic has acted as a powerful reminder that we live in a highly complex and unpredictable world. For hospitals and healthcare organisations, effective responses to the pandemic have required departures from many conventional practices. As noted in this paper, the coronavirus crisis has presented an array of novel and acute transformation challenges for the healthcare sector - from embedding telehealth as a standard model of care, to managing volatile supply chains for personal protective equipment. When planning for the future, it will be important to consider that any proposed solutions are not over-reactions based on the current situation, but rather creative options that are flexible and adaptable for both short term and long-term solutions.

The case studies highlighted in this report offer valuable insights into the practicalities of how hospitals and healthcare organisations can transform in response to a public health event, such as the COVID-19 pandemic. . Whilst many of these changes are not new ideas, the coronavirus crisis acted as a catalyst for their widespread acceleration and adoption. Each transformative example shared offers ideas and learning points which healthcare leaders can draw upon to design and adapt initiatives in their own settings

As hospitals enter their recovery phase post-COVID-19 and start to address the backlog of care and unmet need caused by the pandemic, they will need to maintain openness to radical innovation and learn from what made such a response possible. The need to improvise and adapt will continue for the foreseeable future, to ensure that when the next public health crisis hits, hospitals are prepared. The IHF remains committed to supporting its global community meet this challenge.

The **International Hospital Federation (IHF)** is an international not-for-profit, non-governmental membership organisation. Our vision is a world of healthy communities served by well-managed hospitals and healthcare services, in which all individuals can reach their highest potential for good health.

Established in 1929 by national organisations in over 40 countries, the IHF is the global voice of institutional healthcare service providers. Headquartered in Geneva (Switzerland), the Federation is in official relations with the World Health Organization, and in working relations with many multilateral agencies and global health-related NGOs.

Our members are hospitals and healthcare organisations worldwide, who have direct involvement in the provision of care. We provide our members with a platform for the exchange of knowledge, unique opportunities for global collaborations with different actors in the health sector and access to an extensive network of healthcare leaders. To find out more about our work, download the IHF Institutional Brochure [here](#).

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