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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

13 OCTOBER 2020

MEDWAY COMMUNITY HEALTHCARE COVID-19 RESPONSE AND SERVICE RECOVERY BRIEFING

Report from: Martin Riley, Managing Director

Author: Helen Martin, Director Operations, Clinical Quality and Nursing

Summary

This report provides Members with an overview of Medway Community Healthcare's (MCH) current position in relation to the COVID-19 pandemic and re-commencement of community health services.

1. Budget and policy framework

1.1 Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health service in Medway. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it, and in particular, relevant information provided to it by a local Healthwatch. The Council has delegated responsibility for discharging this function to this Committee and to the Children and Young People's Overview and Scrutiny Committee as set out in the Council's Constitution.

2. Background

2.1 National Situation and MCH responsiveness

2.1.1 Along with all NHS organisations, MCH is required to fully retain their Emergency Preparedness, Resilience and Response (EPRR) incident coordination functions given the uncertainty of COVID-19, possible second wave and anticipated winter pressures.

2.1.2 Since the onset of the pandemic in March, MCH has maintained a robust incident control centre and continues to operate a formal governance structure that has strategic oversight and operational functions to ensure our patients

and staff can safely access services and return to work now that certain restrictions have been lifted.

2.1.3 The following report provides details of the key organisational and service delivery issues, current situation, actions taken to overcome the challenges and begin our recovery programme.

3. Our challenges

3.1 Infection Prevention and Control (IPC)

3.1.1 IPC national guidance has continually changed since the onset of the pandemic and is not always written with community services in mind. MCH has a small IPC team that is led by a Director of IPC who ensures that we are compliant with PHE and other COVID-19 related guidance. This includes the precautions staff take when working with patients or with colleagues; the use of personal protective equipment (PPE); working with estates team to secure COVID-19 safe sites and providing clinical advice for all service areas.

3.2 Personal Protective Equipment (PPE)

3.2.1 All staff have a good understanding of what to use and when. The PPE stock and supply are good and we are able to access mutual aid as required or use alternative PPE available based on a risk assessment of the patient situations.

3.2.2 Patients accessing our services are required to wear face coverings, however we do risk assess and take into consideration those who are exempt and we are trialling clear masks for those with communication difficulties.

3.2.3 Visitors to our in-patient units are risk assessed prior to entering and are required to wear PPE, unless exempt.

3.3 Workforce

3.3.1 At the onset of the pandemic MCH temporarily stopped providing non-essential services, in line with our business continuity plan, and staff from those areas were re-deployed. Additionally, we were pleased to have a small number of nurses redeployed from the Clinical Commissioning Group (CCG) to support our services. Shielding and vulnerable staff reduced our available workforce quite considerably though we enabled as many as possible to work from home. We relied heavily on agency staff; this was however not a reliable source especially when asked to work in areas which meant coming onto contact with suspected or confirmed COVID-19 patients.

3.3.2 We have and continue to assess staff who may be at increased risk - including Black, Asian and Minority Ethnic (BAME) colleagues, pregnant women, returnees, and other vulnerable groups including those with long term conditions or aged over 70 and where possible we made adjustments to their workplace where we could. A specific action plan has been developed across

Kent & Medway organisations to address and support inequalities that have affected our BAME staff disproportionately during COVID-19.

3.3.3 Conflicting and new government guidance regarding social distancing, symptoms and travel has increased the risk of more staff needing to be isolated / working from home.

3.3.4 Staff continue to be motivated though there are some signs of fatigue and we are concerned about the long-term impact on their mental health and well-being so have strategies in place to manage and support this. They have coped admirably throughout the last few months however we are aware of the possibility that sickness absence rates may increase as we move into the winter period.

<u>As from 20 September 2020:</u>
Total staff numbers: 1520
Total staff away from work due to COVID-19: 30
1.97% of total staff

3.3.5 This is a low proportion of staff however this number has started climbing again in the last 3 weeks.

3.3.6 Although we receive continual feedback from managers and staff we have a lessons learnt programme that captures aspects on five subjects (connecting with others; estates; IT and equipment; redeployment; ways of working and wellbeing). The information gained via this route is used to support staff and help prepare for further outbreaks.

3.4 Testing

3.4.1 Symptomatic patients and staff continue to be tested. Staff can access local and regional sites and the results are usually available within 24 hours. There has been a significant push to have all care home staff and residents tested so Darland now have access to the care home portal and carry out weekly patient and staff testing.

3.5 Increased service demand / backlog of work

3.5.1 Services have been under tremendous pressure to recommence services and as the public have become more confident in travelling away from their homes, we have seen an increase in demand such as our urgent care and diagnostic services e.g. MedOCC and phlebotomy.

3.5.2 We know that discharges to care homes have becoming increasingly difficult so we are seeing small numbers of delayed transfers of care in our in-patient units. MCH provides a significant proportion of the discharge pathway services such as integrated discharge team (IDT), discharge to assess home, enablement and intermediate care beds, which we subsequently increased from April. Services are very aware of the backlog of work and as part of MCH and system recovery plans are currently working with the CCG to determine

what the new ‘normal’ will look like, how long it would take to resume full service and risks associated with dependencies such as staff availability.

3.5.3 It is anticipated that there will be a further demand for COVID-19 aftercare support in community health services and alternatives are being sought where care homes are unable to cope with demand.

4. COVID-19 related deaths

4.1 Amherst Unit - Endeavour – 1 death. COVID-19 was recorded on part 1 or 2 of the death certificate as a contributing cause.

4.2 Darland House - Death of 21 residents - 18 at Darland 3 at MFT.

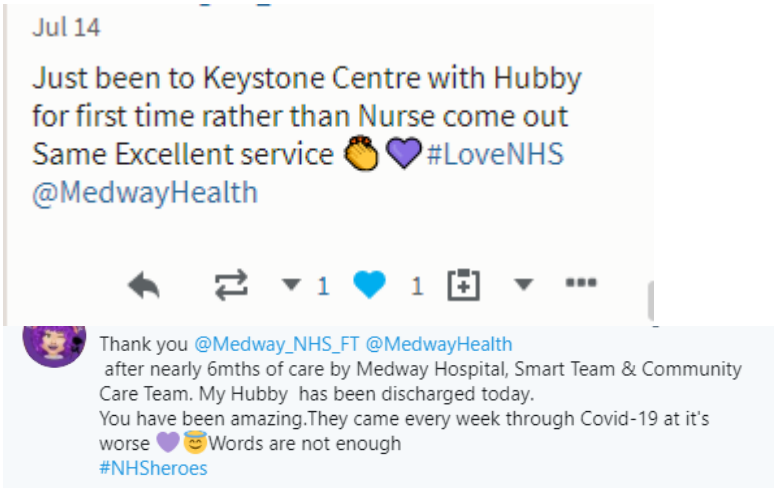
4.3 Wisdom Hospice -15 patients where COVID-19 was recorded on part 1 or 2 of the death certificate as a contributing cause. NB- patients admitted are for End of Life care and COVID-19 isn’t the primary cause of their death.

4.4 Each service area has the necessary IPC arrangements in place; community teams continue to see patients at home and in clinic settings. Where we have mixed risk groups, patients are triaged before offering appointments. The in-patient units care for both COVID-19 / non COVID-19 patients that are either in single rooms or cohorted in bays / units. Darland Nursing Home has a specific isolation policy in place that takes into consideration the capacity of its residents and management of those with challenging behaviours.

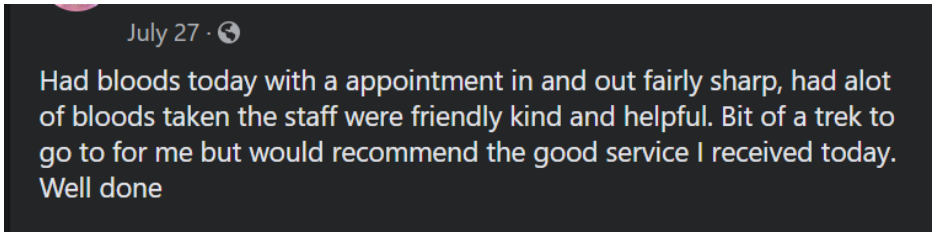
4.5 Visiting has now re-commenced with arrangements based on risk assessment, use of PPE and visitors taking responsibility for advising when they may have symptoms or be in contact with others who are COVID-19 positive.

5. Patient Feedback

5.1 Patients have been positive about the changes to discharge pathways, particularly, during COVID-19, with one example exchange from Twitter, captured below:



5.2 We have also received a number of compliments and positive reviews via the MCH public Facebook page about bookable phlebotomy appointments:



6. Patient Complaints

6.1 Prior to the pandemic our customer care team was in the process of implementing some staff changes to provide a more consistent and accessible service. We are pleased to report these changes are now in place, however the COVID-19 situation has hindered our ability to maintain the standards we strive to achieve for managing complaints. Over the last few months, we have needed to prioritise our patient facing work and redeploy non-essential resources to support frontline services, leading to further delays in responding to complainants. We are now working through our administrative backlog.

7. Service Recovery Programme

7.1 We recommenced our non-essential services during July and aimed at delivering at least 50% of our pre-covid activity levels for each service. During September and October, we aim to increase this to 80%. Yet it needs to be recognised that further social distancing and difficulty in accessing rooms to hold clinics could impact on this.

8. Forward planning next phase

8.1 In preparedness for a number of differing situations MCH has a number of organisational business continuity plans, namely: Essential Community Services Plan, *Emergency Preparedness, Resilience and Response* (*EPRR*) Pandemic Plan (incorporating COVID-19), MCH EU Transition plan, Severe Weather, and Surge and Escalation/Winter Plan 2020/21. These enable appropriate resources to be allocated accordingly to enable care to be provided within the community and in-patient settings to deal with surges in demand etc.

8.2 The MCH Executive Team will ensure effective leadership during emerging pressures to ensure appropriate and timely actions are taken to respond. The appropriate level of organisational representation is essential at times of local health system pressure: increasing seniority of management will be in direct response to escalating pressures.

8.3 MCH are signed up to the principle of partnership working and collaboration to support whole system solutions to surge and escalation. Our organisation will contribute to supporting the local health and care economy by responding collaboratively, effectively and flexibly, maximising capacity during periods of

high and unusual demand. This will include attendance at Medway and Swale whole system surge planning meetings, ICP planning, MCH EPRR meetings and the wider Kent and Medway EPRR led meetings for all providers, as well as specific community provider-based meetings including the local councils.

9. Maintaining Benefits from new ways of working

9.1 We successfully deployed our new IT solution with our new system partner ICOM at the end of March despite the difficulties brought about by COVID. This enabled MCH to support staff to successfully work from home on the new platform, using the latest software and hardware.

9.2 Clinical Teams have been able to offer virtual one on one patient consultations using ACCURx, the same system as primary care. Zoom has been used for group exercise classes. In addition, different systems have been trialled to enable a secure solution for group patient work which will be finalised this month.

9.3 In order to transform our back-office processes, we have been working with a company called Actualised Living. This enabled us to redivert priorities to COVID essential activities. These include an automated staff tracking system to support staff who were redeployed, automation of daily returns for COVID essential data, staff sickness and testing tracking.

9.4 These technologies will support continued new ways of working through COVID, the recovery phase and beyond.

10. New Harmony House Service

10.1 During April 2020 we converted our Cascade, Harmony House unit, into a nursing inpatient facility to increase the number of community beds to enable increased patient flow away from Medway Foundation Trust. This provided an additional 8 beds per day with a potential to increase up to 15 should it be required.

11. New Urgent Response Service

11.1 With increasing numbers of frail patients with complex and long-term health conditions in the community there was a need to implement a reactionary service that enables patients to receive care in their own homes during COVID-19, to avoid hospital admissions.

11.2 In support of Local Care initiatives, MCH implemented urgent response service that integrates with other service providers to enable patients to be supported in crisis in their own homes. This model of care complimented other local care initiatives such as the Integrated Locality Review (ILR) and discharge to assess (D2A) to help support in the community; thus, enabling acute services to concentrate stretched resources on patients that appropriately require acute services.

11.3 The urgent response service model is based on research by MCH, which concluded that if the patient is seen within 2 hours of a crisis, they are significantly more likely to avoid hospital admission and further deterioration. Therefore, based on this data MCH initiated urgent response service to help reduce pressure on the system and provide alternative service provision to our partners (SECAmb, MedOCC, MFT and Social care)

11.4 A working group within MCH was formed on 23 March 2020 to ensure service provision is clinically lead and key service areas such as Advance care practitioners, Community Nursing and MedOCC collectively define service pathway, criteria etc. MCH urgent response service went live on 30 March 2020, clinicians from the following services were re-deployed into the service, to ensure patients receive holistic care in the community:

- Advance community practitioners
- MSK therapists – Physiotherapists to help support patients with sudden deterioration in mobility following falls etc.
- Rapid Response Occupational therapist – To help patient regain functional needs following sudden deterioration after a fall etc.
- Care Mangers – To help support patients, families in case of social and carer crisis.
- Care provider – To help provide wrap around care.
- MedOCC – GP support via Medoc to help avoid hospital admission.

11.5 This 7-day 24 hours service since its launch has proved instrumental in supporting the Medway health/social system. To date the urgent response service has:

- received 782 referrals from various sources of these;
    - 567 avoided acute admissions and
    - 185 SECAmb referrals avoided

12. Discharge Pathways

12.1 Similar to the Urgent response service, MCH in collaboration with other partners (MFT, Medway Council), reviewed and amended the discharge pathways to ensure patients are discharged home safely as soon as possible.

12.2 By introducing joint Council and Health single point of access hosted by MCH, it helped improve patient flow from the hospital, due to joint review patients received therapy and care support services within 2 hours of discharge.

12.3 We also centralised the continuing health care referral process to ensure patients receive optimum end of life support at home, by co-ordinating D2A referrals through MCH SPA, we were able to monitor community capacity and positively influence hospital discharger flow.

13. Risk management

13.1 There are no specific risk implications for Medway Council arising directly from the contents of this report.

14. Financial implications

14.1 There are no financial implications to Medway Council arising directly from this report.

15. Legal implications

15.1 There are no legal implications to Medway Council arising directly from this report.

16. Recommendation

16.1 Members are asked to comment on the report and decide how frequently the Committee would like to receive updates from Medway Community Healthcare.

Lead officer contact

Martin Riley
Managing director
Medway Community Healthcare
01634 334698
martin.riley@nhs.net

Appendices

None

Background papers

None

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