Creating a healthier Hull

NHS Hull Clinical Commissioning Group

Frailty Programme - Response to Covid-19

Hull CCG Board

22nd May 2020

Purpose of Presentation

To provide Hull CCG Board with an update on the Community Frailty Programme's response to the Covid-19 pandemic, to include:

- Background
- Service redesign
- Activity to date
- Learning and next steps

Background

- **July 2018-March 2020 (pre –COVID)**

- **Hull CCG patients**
  - **Proactive care:**
    - Consultant-led, proactive, anticipatory care to patients who are moderately and severely frail with complex needs
    - Enhance care in the care homes setting
  - **Reactive care:**
    - Deliver reactive response arm for frail patients for patients going into or at risk of crisis

  - Interim evaluation completed and awaiting review by Hull CCG Board

Background

- **March 2020 - Current Covid-19 pandemic ICC - Frailty Support Team (ICC-FST) provided by CHCP**

- **Hull & East Riding CCG patients**
  - **Proactive care:**
    - Ceased face to face anticipatory assessments (ICC)
  - **Reactive care:**
  - Service redesign at pace to respond to urgent community demand:
  - 3 elements
    - Specialist Advice and Guidance Line
    - Care Homes Outbreak Support Team
    - Provide enhanced medical care to increased community bed base

ICC-FST Response

1. **SPECIALIST ADVICE AND GUIDANCE LINE** (8am-8pm 7 days/week)

- Aid decision making to support all patients living with frailty regardless of residence (own home, care home, community bed)
- For the majority of patients most appropriate and preferred place of care is in the community
- COVID-19 and non COVID-19 clinical queries
- Community Geriatrician and GPwER delivered
- For use by all community based practitioners (Health and Social Care)
- Aligned operational arrangements between ICC-FST, YAS, Primary Care, Local Authority, Humber FT and community services (i.e. Palliative Care, Pharmacy and Community Nursing)
- Operating model and guidance agreed and endorsed by Hull and East Riding PCN CDs and through HUTHT COVID-19 Ethics Committee

ICC-FST Response

2. CARE HOMES Outbreak Support Team

- 223 Care homes H&ER
- Model mobilised to provide direct support to all care homes in Hull and East Riding with confirmed / suspected COVID-19 outbreak
- Provide individualised specialist support for residents, many of whom wish to be cared for in their own home (care home), in conjunction with the care home team, Primary Care and other services
- Palliative care services actively aligned and involved
- Education, reassurance and appropriate signposting has been a significant part of this process in conjunction with the Local Authority and Public Health England

ICC-FST Response

3. COMMUNITY BEDS

- Provision of additional medical staffing to Community Beds in response to increase in community bed capacity (in response to national guidance to discharge rapidly to create hospital capacity)
  - Acuity of medical care significantly increased (>40 patients COVID-19 positive currently)
  - Redeployment of Pharmacy and Therapy staff

- Step-up patients from own home to community bed to avoid unnecessary hospital admission, where appropriate for the individual

- Advance Care Planning in community bedded units - supported by specialist Advice and Guidance line

Patients Registered to A+G line per PCN

East Riding CCG Total Registered to:-	
Beverley	61
Bridlington	21
Cygnet	7
Harthill	26
Holderness	33
River and Wolds	71
Yorkshire Wolds Coast	24
TOTAL	**243**

Hull CCG Total Registered to:-	
Bevan	65
Medicas	84
Modality	124
Nexus	105
Symphonie	69
TOTAL	**447**

East Riding CCG	35%
Hull CCG	65%

Place of care for total registered patients

Care Home	63%
Own Home	27%
Community Beds	10%

Total no. of A&G calls received since service commenced

Week commencing	Number of calls
23/03/20	19
30/03/20	72
06/04/20	101
13/04/20	170
20/04/20	157
27/04/20	169
04/05/20	187
Total	**875**

Note sustained high level of activity since 13/4/2020

Source of Call for Patient Related Advice

(Week of 4/5/2020)

Source	Number of calls
Care home staff	82
Community bedded unit staff	47
Paramedic	19
General Practitioner	14
Secondary Care FIT	5
Physio	5
Community Nurses	6
Pharmacy	1
Relative	2

Avoidable ED Attends/Admissions

Week commencing	Number of patients
23/03/20	3
30/03/20	13
06/04/20	15
13/04/20	13
20/04/20	22
27/04/20	19
04/05/20	31
Total	**116**

Likely under reported in initial weeks (templates now amended)
Preferred place of care / death achieved for the vast majority of patients

Dashboard

- In development (Hull CCG)
- To facilitate escalation and de-escalation as the crisis evolves
- Including:
  - activity in:
    - Acute trust
    - Care homes
    - Community beds
  - Patient and staff numbers confirmed COVID-19
  - Mortality secondary to COVID-19

Feedback

Yorkshire Ambulance Service

- **Deputy Chief Executive:** "Our rate of conveying patients to hospital after being attended by a paramedic is currently at its lowest ever point and it looks like this service is likely to be playing a positive part in enabling that in the area"
- **Lead Clinical Pathways Manager:** *"really pleased the uptake by crews has been so positive and you've been able to provide them with support around their decision making at this difficult time. I'm pleased it is working so well, it's a really beneficial model"*

Feedback

Care Homes

- **Provider:** *"Thankyou for the support today! It's made EVERYONE feel more at ease"*

Feedback

Acute Trust

- ***Medical Director:*** *"*very grateful for the system wide response"
- **Consultant Elderly Medicine:** *"*Helpful and reassuring to know what support is out there for when we discharge patients back into the community"
- **Consultant Infectious Diseases in reference to our guidance to primary care:** *"This is the most awesome document I've seen in a long time! It's brilliant and absolutely what is needed"*

Feedback

CCG

- **Director of Integrated Commissioning:** *"Very positive messages from HCC on the system Covid19 call about the support to care homes, particularly speed of responses and giving them confidence with managing C19+ patients"*

Critical Success Factors (1)

- Strong Clinical Leadership
- Experienced leadership and support from CCG Clinical Chairs and Associate Medical Director (Hull CCG)
- Engagement and endorsement PCN CDs
- Collaborative working with primary and community care
- Effective communications structures
- Analytical support

Critical Success Factors (2)

- Seamless record sharing organised at pace
- Introduction of electronic ReSPECT form
  - Accepted by YAS
- Access to volunteers/redeployed CHCP staff available to collect and deliver medications to patients urgently
- Initial guidance, on-going support and engagement from ICU, Infectious Disease, Palliative Care and Respiratory Consultants
- Previously established knowledge and understanding of population needs enabled rapid service re-design, including working relationships

Benefits

- **Patients are being cared for in their preferred place of care with reduced inappropriate admissions as a direct result of the interventions of the ICC-FST**
- Care homes are being directly supported during an outbreak
- New pathway and support for paramedics at the scene is well utilised with increasing demand
- Support to community bed base increasing step up capacity as an alternative to hospital admission
- Improved integration of CHCP Trusted Assessor team, allowing discharge to assess model to be implemented
- One care plan and improved information flow
- Allowed rapid implementation of a reactive frailty service, with lessons learned to inform future model

Adverse Impacts

- Patients who are moderately or severely frail benefitted from the anticipatory service offered Pre Covid-19 to optimise their health and avoid crisis

- Lack of this pro-active anticipatory care will result in higher demand on reactive care (community and hospital based care) and may lead to a decline in their quality of life

- Withdrawal of integrated social care team (due to the need for them to respond to business continuity)

Next Steps

- Need to be considered alongside the ICC Interim Evaluation report (July 2018-March 2020)
- Robust and timely data analysis to inform operational resilience and planning
- Recovery plans in development - Wider service redesign and alignment to community services and primary care
  - Reactive element to be maintained
  - Proactive element to be re-established including social care
  - Workforce review to sustain new model
  - Other specialist services to be re-instated (e.g. community Parkinson's, COPD, Dementia, Diabetes frailty services)
- Leadership and resource required to mitigate against the risk of destabilising the excellent outcomes achieved pre-COVID-19 for anticipatory care

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Thank you

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