**COVID-19 update**

**Information correct as of 10.15pm 10 May 2020**

**Attachments**

* None

**\*\*\*URGENT\*\*\* Crisis in care homes – requirement for whole system support**

**A message from Michelle Carrington, Executive Director for Quality and Nursing**

We are all understandably concerned about the increase in the spread of Covid-19 and subsequent deaths we are seeing in some of our care homes and we all recognise the need to act urgently.

Last week the CCG were required to commence urgent work to support care homes who are at increasing risk of outbreaks of Covid-19. The response that the CCG has asked to be a leader in involves partnership working with the Local Authorities and Primary Care. Last week I was able to urgently brief the Primary Care Operational Group, the Primary Community Interface Group, York Central PCN meeting and the Vale System Working Group as well as the CCG Governing Body. I hope that messages have filtered from those briefings to primary care colleagues more widely.

This letter outlines a request for further urgent support and responses to our vulnerable residents in care homes.

I really appreciate you are all doing some fantastic and innovative work already and that these requirements may already be in place. I hope that by all partners coming together you will feel that you are able to call on extra resource or expertise to help you look after your registered patients in care homes.

**Background**

Public Health modelling data is clear that a crisis has started to develop in care homes with 90% expected to experience an outbreak of Covid-19 within 6 weeks if further interventions are not in place – we can see this is already happening in our area. Additionally by the time an outbreak is reported, Covid-19 infection can be widespread in the home. Learning from outbreaks tells us that key drivers for spread are the movement of staff between care settings and that there is a need for increased support for infection control principles and practices in every day interactions.

Importantly the care sector experiences staff turnover rates nationally of 32% so the impact of self-isolation on the workforce is significant.

It is clear we need to move from not only outbreak management but to a preventative model with support from all partners.

**Purpose and values underpinning the requirements**

Using a population health approach based on the high need of those resident in care homes and their associated vulnerability we will aim to:

* Prevent outbreaks and
* Reduce deaths and suffering

**What is required from primary care?**

Sir Simon Steven’s outlined, in his phase 2 letter, there is to be a greater emphasis on care homes. The new ‘Principles to Deliver an Enhanced Universal Support Offer to Care Homes’ issued to CCGs last week outlines the specific requirements.

Separately, but aligned to this, Local authorities are required to establish and mobilise a support offer to homes. They have been working on their plans to further support care homes and will be required to detail these plans to central government in the next 2 weeks.

As you are aware the national DES to support care homes is unlikely to be in place soon but the principles in that document are ones we would want enacted now.

We are clear that all our plans will come together to describe one partnership offer described as ‘Team Around the Home’.

There is a requirement for a primary care sitrep and a CCG assurance framework to be submitted on progress against the interventions with the first submission due on **13 May 2020**. The CCG will lead the submission working with you on the detail.

**Interventions required by primary care**

**It is important to note that the definition of care home is ‘CQC registered with and without nursing’ and therefore this includes residential care homes, nursing homes and learning disability homes.**

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|  | **Intervention required** | **Comments** |
| 1 | To identify a named clinical lead for each care home | We are aware that PCNs are in the process of encouraging the registering of patients against the ‘one care home one practice model’ and while that is happening in an accepted phased way, a clinical lead will still need to be identified.  The CCG is writing to care homes to encourage residents to re-register to the one home one practice model where needed in the context of this additional support from partners. |
| 2 | Establish weekly ‘check ins’ with each home. This needs to be multidisciplinary in nature drawing on expertise and support as required for your population needs and can be a virtual ‘check in’. | The acute and mental health trust (and others) are working with us to describe the clear offer to practices to help with this in addition to what you might already have in place. **This may include:**  Meds management support  Specialist nursing support  End of life support  Geriatrician support  Mental health and dementia support  Therapies support  The aim is to move away from a provider caseload approach to one where the whole population belongs to us all and the MDT is the conduit to that. |
| 3 | Development of a process and establishment of personalised care plans including advance care plans | The CCG is offering additional support through Dr Aaron Brown  who will lead and coordinate the work across the CCG footprint on Advanced Care Planning (ACPs) for patients. This is intended to improve and standardise the quality of patients’ ACPs by learning from the great work that is already being done, sharing best practice and joining up communications to prevent effort duplication. Aaron will be in touch with practices but also welcomes you contacting him. |
| 4 | Clinical pharmacy support including medication reviews | See below |

**Medicines Management Support from the CCG**

The CCG Medicines Management Team will provide co-ordination for the offer of the provision of pharmacy and medication support to care homes. This provision will come from the existing Medicines Optimisation in Care Homes team and PCN Pharmacists to:

* **facilitate medication supply to care homes, including end of life medication**
* **deliver structured medication reviews – via video or telephone consultation where appropriate - to care home residents,**
* **support reviews of new residents or those recently discharged from hospital**
* **supporting care homes with medication queries, and facilitating their medicines needs with the wider healthcare system (e.g. through medicines ordering).**

The Medicines Management Team will provide guidance and/or direct to the most appropriate source of provision, based on the answers received from care homes for the two questions:

* Are there any problems accessing medication supplies that you need to report, especially end of life medicines?
* Are there any new or unstable patients, including those just discharged from hospital, that require a medication review or advice from a pharmacist?

Care Homes are encouraged to direct requests for pharmacy/medication support to one central mailbox: [VOYCCG.Rxline@nhs.net](mailto:VOYCCG.Rxline@nhs.net)

The Medicines Management Team are also liaising with Community Pharmacy North Yorkshire to establish if pharmacy/medicines provision to care homes could be further supported by Community Pharmacy.

**Infection Prevention and Control (IPC) support from the CCG**

We have established a ‘train the trainer’ approach to support IPC and as such will have trained a number of individuals who will train care homes in essential IPC practice and ensure the principles and equipment are being used effectively. We will inform practices who their link IPC person is in the next week. In the meantime we are already responding to care homes with the clinicians we have in place. If you wish to call on this resource please email [sarah.fiori@nhs.net](mailto:sarah.fiori@nhs.net)

We are working closely with local authorities and the Local Resilience Forum (LRF) to establish clearer and improved routes to Covid-19 testing for care homes.

**Support from other providers**

York Teaching Hospital NHS Foundation Trust (YTHFT) are developing a comprehensive guide to accessing specialist support including wound care, continence and long term conditions and establishing coverage to enable a registered nurse to contact each care home every day to provide support.

They are also required to set up a process for visiting patients discharged to care homes the day after their discharge.

We are required to establish a 24/7 helpline for care homes for *advice on Covid-19*. We are exploring how best this might be provided likely from existing resources.

It is important that care homes are provided with good psychological and bereavement support and this has been established through TEWV and St Leonards Hospice.

End of life services have already been established through the single point of access process through St Leonards Hospice which you are already aware of. We are also exploring with them a training offer on end of life to care homes.

**Monitoring and escalating support to care homes**

Care homes are required to complete the national Capacity Tracker each day which provides certain information about bed vacancies, Covid-19 status, deaths, IPC, workforce issues etc. The local authorities are then phoning care homes on a daily basis asking standardised questions to determine risk and mobilising any additional support.

Each day at 8am across NY&Y (local authorities, CCGs, CQC, public health) colleagues come together for a ‘care home gold’ meeting. Care homes are risk stratified across a matrix of indicators and working in partnership agree any further support required. This is the route where requests for Covid-19 testing is likely to be managed and is already the route for mobilising the additional IPC support described earlier in the letter.

The matrix of indicators (dashboard) is being standardised across the two local authorities (CYC and NYCC) and will be available for primary care colleagues to view (likely on the RSS on the CCG website) and we need to establish a mechanism for primary care to input into this dashboard with any information or intelligence you have on the care homes you are supporting. I welcome your views on how we might do this and what information you would like to see.

As soon as I can, I will communicate out further information regarding the overall partnership offer to care homes to support you in your continued efforts to deliver enhanced healthcare in care homes for our most vulnerable people.

Please contact me ([michelle.carrington1@nhs.net](mailto:michelle.carrington1@nhs.net)) if you require further information, have any ideas or wish to discuss anything.