HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 7
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INNOVATION AND COLLABORATIVE WORKING IN LIGHT OF COVID-19

R E C O M M E N D A T I O N S

It is recommended that the Peterborough Health Scrutiny Committee discuss the innovations and collaborative work that has been developed during the COVID-19 pandemic and note the recovery planning work already undertaken to date.

1. ORIGIN OF REPORT

1.1 This report is submitted to Peterborough Health Scrutiny Committee following a request from the scrutiny members and Chair present at the Group Representatives meeting on 3 August.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide information requested by the Committee for consideration.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview Scrutiny Functions, paragraph No. 2.1 Functions determined by Council:

Part 3. Scrutiny of the NHS and NHS providers.

3. BACKGROUND AND KEY ISSUES

3.1 Since the Covid outbreak began, our response within the Cambridgeshire and Peterborough health and care system has been to ensure we have the capacity to support and treat patients, to maximise survivorship and to keep staff safe.

The Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) continues to implement Phase 2 of the system-wide recovery Plan and to progress plans for Phase 3. We are completing the modelling of capacity available in detail so we can understand the demand for each of our services. Alongside this we are reviewing the constraints on this capacity and identifying solutions to resolve these.

As well as our focus on recovery, we are required to maintain our Incident Response, and ensure that we have robust arrangements in place, if there is a further peak in Covid-19 cases, or a second wave. The CCG continues to chair the system-wide Health Gold meeting of Chief Executives and Accountable Emergency Officers across the health system, and to co-chair the Cambridgeshire and Peterborough Local Resilience Forum Strategic Co-ordination Group. We

continue to ensure we have the right resources in place to man our Incident Co-ordination Centre Function.

From a multiagency perspective, the Strategic Co-ordination Group is overseeing the progress of the Local Health Protection Board which has been built on existing structures. It is now meeting weekly and is chaired by the Chief Executive of Cambridgeshire County Council and Peterborough City Council.

4.0 INNOVATION AND COLLABORATIVE WORKING

4.1 Care Homes

As the COVID-19 pandemic progressed, it quickly became clear that the 174 Care Quality Commission (CQC) registered nursing and residential homes in Cambridgeshire and Peterborough would need significant additional support at speed from both the NHS and Local Authorities (LA).

In early April, the LA and Cambridgeshire and Peterborough CCG developed a Standard Operating Procedure to agree a joint way of working to support local care homes. This early work ensured that we had a collaborative approach well in advance of the peak.

In line with national guidance 'COVID 19 Hospital Discharge Service Requirements' the CCG worked with the Local Authority to identify and commission spare capacity in the care home sector to aid speedy discharge from hospital. The LA acted as lead commissioner, putting block agreements in place for an agreed period of six months for 340 residential and nursing beds across Cambridgeshire and Peterborough.

A national capacity tracker was introduced to gather data from care homes on the number of vacancies, staffing levels, COVID outbreaks and Personal Protective Equipment (PPE). Care homes were required to complete this daily and the information was used to inform the LA and CCG Quality Teams of developing situations. The CCG contracts team have supported providers to register and encourage regular updating.

Prior to the pandemic alongside the LA Quality and Contracting teams, the CCG already had a very proactive care home support team focussed on delivering high quality training and support in care homes, with Infection Prevention and Control (IP&C) nurses well connected, although there were solid foundations to build upon, additional resources were required due to the rapidly increasing work. Both the LA and CCG identified Senior Leaders to coordinate the work and the CCG redeployed additional staff from the Continuing Health Care Team.

The CCG has recognised that this sector will require additional ongoing support from the NHS and has committed additional staffing resource to its Infection Prevention and Control (IP&C) team and Care Home team to ensure the sector continue to have training and support as required.

4.1.2 **Training –** we recognised early on the need for training around PPE application and understanding legislation to support Mental Capacity Act and Deprivation of Liberty Safeguards during isolation.

An incident lead and a social worker has been assigned to each home to support and identify needs. Ensuring a good level of knowledge across all care homes has been vital to minimising the spread of COVID-19.

We offered a range of training options including reactive training tailored to the individual needs of the home (delivered virtually or on site), and intensive training where CCG Nurses were redeployed to work alongside care home staff to ensure IP&C measures and the application of PPE were accurate, sufficient and operating well.

The CCG's 2 infection control Nurses had received national training on the use of PPE and by the 29 May 2020 the CCG had 12 'super trainers' and a further 56 locally trained staff including social workers and District Nurses. The team trained staff across a total of 157 homes.

4.1.3 **Infection Prevention Control and Swabbing -**
The CCG recognised the need to ensure there was a consistent approach to Infection Prevention and Control (IP&C) across the health and Social Care System. A System wide IP&C meeting was introduced (this now reports to the Health Protection Board) Chaired by Jan Thomas and attended by the NHS Provider Directors of Infection Prevention (DIPC) as well as representation from Public Health, Public Health England and Primary Care.
The CCG also recognised the need for additional expertise in Infection Prevention and has increased resource within this specialist team

The CCG was fortunate to already have a commissioned provider, Commisceo, providing care home testing for Influenza-like illness. Public Health England 'turned off' this screening, allowing us to switch to requests for COVID-19 swabbing in Care homes and other residential settings.

This commenced on 20 March 2020 and will continue as necessary. The approach to swabbing is driven nationally and the CCG continues to adapt local process in response to national requirements. In particular for the care home sector it has caused some complexities as initially there was capacity constraints at laboratories which meant delays in swab results, the CCG worked closely with PHE to mitigate this and arranged for the CCG IP&C Lead to receive results directly in order to be able to support homes and residential settings to instigate any necessary actions to minimise spread of infection. The complexities with swabbing continue for care homes in that they need to access both Pillar one and Pillar two testing routes, the CCG and Local Authority continue to support the sector with training and guidance to facilitate them accessing swabbing in a timely manner.

4.1.4 **Technology** – our digital team worked closely with care homes to ascertain their current digital capacity for enabling functions such as remote ward rounds. Many homes have now been provided with equipment to allow for virtual monitoring of residents' vital signs and early reporting of any changes or anomalies. Care homes have been provided with:

- Pulse oximeters
- Temperature probes
- Blood Pressure monitors and cuffs

As well as training and tablet computers to allow for remote consultations with Primary Care and other clinical staff.

4.1.5 **Medications** – Our system has come together to create a collaborative medicines optimisation clinical service model for care homes with all partners contributing to the delivery of our model.

We have been working closely with GP Practices and community pharmacies to ensure that care home residents receive their medications by managing supplies and reducing the impact of stock shortages, and also implementing new processes for online ordering to reduce face to face contacts.
This has been vital for all patients, but particularly with respect to the availability of palliative care medications.

4.1.6 **GP and wider health team support** – our local GPs have been working hard to provide our care homes with the support they need to care for their patients.

As with all patients this work has often relied on virtual consultations in the first instance, with visits when clinically necessary.

Each care home has a named lead clinician and we are rolling out multi-disciplinary team working via Microsoft Teams, including GP practice, community services and care home staff.

We have also developed a suite of End of Life Care guidance which encompasses care homes, including 24/7 support via our local hospices, and rapid access to GP clinical advice out of hours.

4.1.7 **Communications support** – we have provided media management support to homes where required, including linking in with the LA and Public Health England (PHE) to ensure accurate and consistent messages are shared.
The CCG has also supported the LA with their weekly video conferences held with care home and domiciliary providers with clinical experts to offer advice and answer queries.

4.1.8 **Daily updates** – care homes and other care providers receive daily updates sent jointly from the CCG and LA.

All new guidance, testing processes, suppliers for PPE, medicines optimisation updates, information on national trackers, support for remote working offers and a huge range of other information has been distributed daily through theses updates.

4.2 **Mental Health**

Mental health and Learning Disabilities Services adopted the whole system response to COVID-19.
We ensured System collaboration and links with the Community Resilience Group.
Our key principles throughout the incident management were:

- patients and staff safety,
- patients voice and co-production, and
- collaboration with our voluntary sector

Below examples demonstrate some of responses we deployed across mental health and learning disabilities services.

4.2.1 **Crisis Services** - all key crisis support services are continuing to operate at full capacity to provide both non-urgent and urgent support.

A non-urgent Lifeline helpline has been introduced, providing support Mon-Fri from 9am to 2pm and from 2pm to 11pm seven days a week.

The service is alleviating pressure on urgent crisis services such as the First Response Service. The system has been successful in securing £50,000 of national monies to expand the service and extend from three to six months.

4.2.2 **Local Mental Health Campaign** '#Now We are Talking' Lifeline has been promoted through the #Now We're Talking campaign.
The next stage of the campaign is the distribution of 35,000 leaflets to extend promotional work through traditional routes in addition to social media.
The aim is to ensure we reach people that are not able to access information via digital means.

4.2.3 **Bereavement Support** - more than 60 staff across voluntary and statutory organisations have received bereavement training delivered by Cruse Bereavement Care.

Take up has been excellent from a variety of organisations, particularly those staff supporting the Lifeline Telephone Service.

The CCG also recognised that care home were facing the tragic loss of their residents over a short period of time, and by way of support commissioned three different health and wellbeing services providing access to counselling and support which has been utilised by many of the local homes across they system

4.2.4 **Virtual Memory Assessments -** a pathway for virtual memory assessment for older people is being developed collaboratively by a number of providers nationally.

The Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Clinical Director for Older People's Mental Health is part of this group and virtual memory assessments are expected to go live in the next few months.

4.2.5 **Children and Young People's Services** - teams have been working to provide appropriate crisis support during the outbreak.
Fullscope (a collaborative of third sector providers) have been awarded additional resources from the CCG COVID-19 fund and Peterborough Council for Voluntary Services to provide a wellbeing call service for Children and Young People (CYP) up to 18 years of age.

Work across the system has begun to develop a Multiagency approach for CYP's Mental Health. The aim is to extend further and include other statutory and voluntary sector providers to have joint assessment of referrals with the aim of reducing bounce between services that CYP often experience.

4.2.6 **Services for People with Learning Disabilities and Autism** - it is a testament to the local system work that the mortality rate of people with learning disabilities as far as we know, is no different to the last year. Whilst national data indicates 134% increase in mortality of people with learning disabilities due to COVID-19.

A fully comprehensive approach in response to COVID -19 was put in place for people with Learning Disabilities that includes the following interventions:

- Introduction of additional community crisis beds
- Case load stratification to enable a proactive, preventative approach to patient/carer support and management
- Wellness and care calls to patients
- Links made to the vulnerable people coordination hub
- Implementation of required reasonable adjustments and national guidance

The learning disabilities, complex cases and quality teams have worked together since the outbreak to ensure reasonable adjustments were put in place in acute settings for people with learning disabilities.

4.2.7 **MH Inpatient Settings** - supporting patients and staff across mental health inpatient settings has been a priority during the outbreak and subsequent restoration phase.
Although many MH services are now moving towards restoration, issues around inpatient staffing are causing a ripple effect across CPFT and may continue to do so for some time.

The Sustainability and Transformation Partnership Mental Health and Learning Disability Board is working collaboratively with key partners to look at solutions that will help over the next few months.

4.2.8 **Minority Ethnic Groups and Mental Health** - a task and finish group has been set up with representatives from minority ethnic groups, third sector organisations and primary care to inform Mental Health (MH) and Learning Disability (LD) restoration and recovery plans.

The group has identified 'access to services' as a priority theme which includes specific areas such as interpreting, language and cultural narratives in mental health and reviewing data around access to services.

This group is currently focused on the community mental health exemplar in Peterborough and will move to supporting system developments around MH and LD over the next few months.

4.3 **Primary Care**

From early March 2020, Cambridgeshire and Peterborough Health System has been in a state of national emergency and 'Command & Control' in response to the threat of widespread Covid-19 population infection. In reaction to this, we have worked with GP practices, GP Federations, Local Medical Committee (LMC) leads, medicines optimisation leads, NHS 111 provider colleagues and wider system partners to ensure sustainability and business continuity of our

primary care services for patients, whilst reducing the risk of infection to patients and staff whilst still providing the best quality care.

During this time, we have developed numerous new ways of working and embedded digitally enhanced best practice to dramatically reduce footfall in practices, manage suspected Covid-19 patients safely (in practice and the community). We have also maintained GP clinical oversight of high-risk patient groups and community Covid and non-Covid patient management pathways.

4.3.1 **New ways of working**

General Practice:

- IT and Digital solutions to allow remote working functionality for all practices
- 100% telephone triage for on the day /routine demand, enabling most patients to be treated remotely, but face to face consultations and home visits are still taking place where clinically necessary.
- Video/Telephone Consultation software used in all practices for on the day demand and high-risk patient groups i.e. in care homes
- All practices using electronic prescribing
- Hot/cold designated areas in practices to keep patients safe.
- Contingency Plans in place if required to manage demand surges, staffing crises, practice closures for branch sites, use of hot and cold sites within geographic localities, working with the Federations and the Granta Primary Care Network (PCN)
- Significant system work to produce and agree Primary and Community management pathways in place e.g. Covid Primary Care Pathway, End of Life Care flowchart and symptom management guidance
- Additional support to Herts Urgent Care and COVID Clinical Assessment Centre (C-CAS) to manage COVID calls
- Collaborative approach to managing and changing provision within community services
- Clear communications to care homes about access to primary care and community care
- Daily practice sitrep calls introduced which enables early support to practices from the CCG and Federations, including the provision of PPE for primary care and pharmacies
- Increased clinical oversight and multidisciplinary teams (MDT) intervention for care homes
- Working with Federations and Local Medical Committee (LMC) to ensure 'Test and Trace' practice workforce and site operational sustainability

4.3.2 **NHS 111/Out Of Hours (OOHs) – Herts Urgent Care (HUC):**

- Joint approach between GP practices and HUC to manage Bank Holiday demand
- Re-purposing of Extended Access service to provide on the day capacity and clinical triage support to the NHS 111 service
- Rapid adoption of processes agreed for GPs providing remote triage capacity to NHS 111 and GP out of hours services
- All practice systems re-configured to accept direct booking of patients from the national NHS 111 Covid Clinical Assessment Service
- Remaining EMIS practices enabled for direct booking from NHS 111. EMIS is a software used in GP practices for keeping patient electronic records and managing appointments and prescriptions etc.
- Use of remote consultation software in Out of Hours bases
- Leading work for NHSE East of England Region for NHS 111 front door solutions and direct booking into Emergency Department (ED) and other in-hospital Same Day Emergency Care (SDEC) services

4.3.3 **Community Pharmacy & Medicines Optimisation**

- Collaborative working with Local Pharmaceutical Committee (LPC) and system Chief Pharmacists
- Improved engagement with community pharmacists
- Support given with staff shortages

- PPE and screens supported
- Sourcing and management of medicines shortages
- Communications to the system and escalation of issues nationally

4.3.4 **Recovery plan for primary care**

As we move into the recovery phase we would like to move to a new version of 'normal' for primary care services. This will involve maintaining and building on some of the new ways of working, as well as continuing to work with system partners to ensure integrated and efficient care provision for patients. We believe this can be achieved in the following ways:

1. Ongoing work with primary care partners to ensure latest digital innovations and equipment are used to continue remote consultations, both with on the day demand and high-risk patient groups i.e. care home residents

2. Explore at pace remote clinical consultations, including Advice & Guidance, and outpatient clinics for clinician to clinician, and patient to clinician, diagnosis across our system, including community, primary care and acutes

3. Work with provider and primary care partners and care homes using remote clinical consultation software to same level as primary care to benefit both patient, and clinician to clinician, interaction and introduce training and equipment for diagnostics

4. Maintain use of electronic prescribing in all practices and in Herts Urgent Care/NHS 111 to ensure efficiency and increase on the day demand turnover

5. Think more strategically about branch site/community hub usage for low-risk and routine primary care activity to ensure more local care for patients

6. Work with system partners to ensure smooth and efficient referral routes and pathways to community and acute services for patients

7. Continue to work with the LMC and GP Federations for day to day management of and give support to practices

8. Continue work to enable transfer of low acuity patients from East of England NHS Ambulance Trust (EEAST) to the local NHS 111 Clinical Assessment Centre (CAS)

9. Complete evaluation of Urgent and Emergency Care (UEC) Collaborative pilots

10. CCG teams will continue to work and support local Community Pharmacies building on existing and new connections, to develop Community pharmacy as an integral part of local PCNs, in collaboration with NHS England

11. Seek to improve communication links with our Community Pharmacy partners, through innovative IT solutions, such as Pharma outcomes

12. Support and work with Community Pharmacies to ensure equitable, safe and timely access of medicines to our patients, by supporting resolution of staffing issues, opening hours and delivery queries

The way we have worked over the last few months, both in crisis management and recovery thinking is similar to the work already undertaken within the UEC 'Roundtable' Collaborative. This mode of collaborative working has extended across the systems and can be the vehicle to achieve all the above and promote system working, but a higher level of interaction and guidance from primary care partners would be required.
Many elements of the NHS Long Term Plan for Primary Care have been achieved or work has commenced ahead of schedule over the past few weeks. The Covid-19 crisis has presented us

all with challenges but also many opportunities and we should take stock of these now and plan what the new 'normal' will look like for services and patients collaboratively.

We are now focusing on how we can improve patient communications so that people understand that while there might be notices on doors and doorbells, Primary Care is very much 'open for business'. These precautions are for the safety of patients and staff alike. As with the rest of the country, we are operating on a telephone triage first process where a clinician speaks to the patient and agrees whether a call, video consultation or face to face appointment is clinically needed. They may also just be able to give advice over the phone, there and then.

5. RECOVERY PLANNING

5.1 In April we began planning our approach to restarting work that had been paused due to Covid. This work was undertaken in the context that we would have to live with the disease until a vaccine or treatment becomes available. It was also undertaken with the knowledge that a potential second wave was possible and therefore we needed to retain the ability to quickly 'step up' capacity to deal with Covid cases should this be required. We have continued to monitor the data around case numbers since April and use this information to inform our plans.

Our initial plans assumed a period of 12-18+ months of managing Covid disease alongside a sustainable model for non-Covid healthcare. Our goal, as a system, was to implement a sustainable clinical and operating model for this period, allowing for future increases and decreases in case numbers, and with the primary aim of maximising the survivorship of patients and protecting our staff

We have had an opportunity to use the recovery period to think about how our services should run and to make our recovery plan and the system's transformation plan one and the same thing.

A further aim of the recovery planning process was to ensure that as we began to restart services, we captured and sought to incorporate the benefits of the new ways of working introduced during the peak of Covid, with the aim of embedding them in future ways of working. We have undertaken work to review the positive changes introduced during Covid so that we can decide whether to retain them or to go further and make more radical changes.

We have also sought to act on the clinical view of prioritisation, including ongoing clinical prioritisation of the waiting list across all procedures so that those at most risk of harm are treated most quickly. In addition, we have sought to provide the public with the confidence to seek care where appropriate and necessary. This has included ongoing clinical prioritisation of the waiting list across all procedures so that those at most risk of harm are treated most quickly.

We agreed a set of core principles to guide planning

a) Maximise health benefit in the context of limited resources
b) Stay close to the clinical evidence base
c) Reduce health inequality
d) Focus on clinically designed whole pathway interventions

To support our ongoing approach to recovery planning we have set up a Recovery Oversight Group. This group brings together Chief Operating Officers and Directors of Strategy from across the system, from the local authority and the NHS, to lead the recovery process. The group is leading four domains to focus on specific aspects of recovery:

<u>Domain 1: Out of hospital care</u>

- Primary Care and Medicines Optimisation
- UEC Collaborative
- Community Care
- Care Homes/Continuing Healthcare
- Mental Health Services
- Discharge to assess

Domain 2: Clinical Interface

- Advice & Guidance
- Medicines Optimisation
- Direct Access Diagnostics
- Prioritisation of Service Start

Domain 3: Hospital Care

- Older People
- Diagnostics
- Electives Care
- Cancer
- Critical Care
- Urgent Care & Flow

Domain 4: Maternity & Children's Services

- Maternity
- Children's Services

Our current focus is on restoring services to pre-Covid levels and work is undertaken through the groups listed above to achieve this.

6. REASON FOR THE RECOMMENDATION

6.1 Peterborough Health Scrutiny Committee members are invited to note the collaborative and innovative work that has taken place during the COVID-19 pandemic and the resulting good practice. Also, to note the steps taken by the CCG towards recovery planning.

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